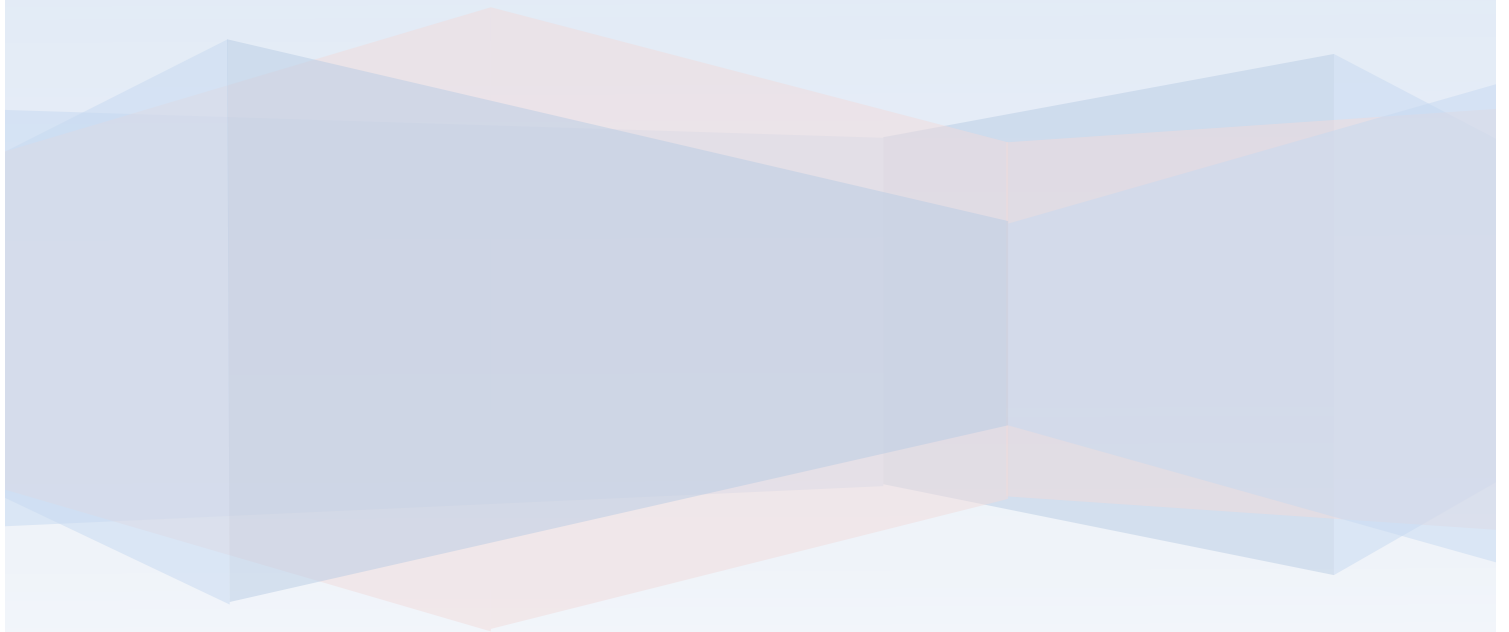


The Perceptions and Experiences of Acupuncture users

A New Zealand Perspective



A thesis submitted in partial fulfillment of the requirements for the Degree
Master of Health Sciences

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Dedication

To my Parents

'The philosophies of one age have become the absurdities of the next, and the foolishness of yesterday has become the wisdom of tomorrow.'

- William Osler, Canadian physician

List of Abbreviations

ACC: Accident Compensation Corporation

CAM: Complementary and Alternative Medicine

CER: Comparative Effectiveness Research

EBP: Evidence Based Practice

EHR: Electronic Health Record

GPs: General Practitioners

IM: Integrative/Integrated Medicine

NZRA: New Zealand Register of Acupuncturists

NZASA: New Zealand Acupuncture Standards Authority

OPP: Out of Pocket Payment

QARI: Qualitative Assessment and Review Instrument

RA: Rheumatoid Arthritis

RCTs: Randomised Controlled Trials

TCM: Traditional Chinese Medicine

WHO: World Health Organisation

Notes to the reader

While there are many different styles of acupuncture (TCM, five element, Japanese, etc.) and it is widely debated whether “Chinese medicine” can be accurately conceptualised as a singular discipline, it is generally agreed that the various schools of acupuncture adhere to a common unifying conceptual framework (yīn/yáng, qì, meridians, etc.). Throughout this thesis the terms “traditional” and “Chinese medicine” are thus used somewhat interchangeably.

I have chosen, for the sake of consistency, to use pinyin Romanisation of all Chinese terms, so while some commonly used Chinese words such as *Taoism*, or *Ch’I*, are often rendered in their historic Wade-Giles form, I have used *Daoism*, and *qì*, etc.

To facilitate the fluidity of reading, I have tried to keep capitalisation to a minimum. It is conventional however, that English transliterations of Chinese medicine terms are capitalised where they do not correspond directly to biomedical meanings. *Spleen* for example is used when it refers to the Chinese medicine notion of the *Spleen system*.

In the analysis of results my explanations and interpretations within participants’ quotes are parenthesised in square brackets and intentionally omitted phrases are depicted by ellipses.

Abstract

The use of Complementary and Alternative Medicine (CAM) is now widespread and endeavours are increasingly being made to incorporate CAM into conventional healthcare and move towards Integrative Medicine (IM). To date research has primarily focused on the prevalence of use, and safety and efficacy of CAM; less is known about patients' experiences of and reasons for using specific therapies. While therapeutically diverse, it has been suggested that many CAM modalities share mutually referential ideologies and that people who use them may be motivated to do so by specific health beliefs.

This study focuses on traditional acupuncture in a New Zealand context and investigates users' experiences and perceptions of the therapy, and discusses how personal health beliefs influence usage.

A systematic review of relevant international qualitative research informed the main study, which was carried out using an interpretive phenomenological methodology (Heidegger's approach). Data was gathered from interviews with 12 participants who had recently received treatment from traditionally trained (non-biomedical) acupuncturists.

Thematic analysis suggested that acupuncture was often sought for health conditions (typically of a chronic and benign nature) that are difficult to treat conventionally. Whereas initial access was primarily motivated by ineffective biomedical treatment, personal health beliefs—particularly subscription to holistic and vitalistic ideologies—often inspired more extensive and ongoing use. The therapeutic encounter was interpreted to contain many elements—other than needling—integral to treatment. Outcomes were perceived to be wide ranging, personal and necessarily subjective, and included the relief of

symptoms, increased well-being, and changes to understandings and health behaviours.

It is concluded that the attraction of acupuncture for patients and many of its perceived benefits lie in therapeutic components that are ultimately embedded in Chinese medicine (holistic) theories of health. A more pluralistic schema for assessing evidence may be necessary to acknowledge treatment outcomes that are meaningful to patients, and to accommodate the divergent ontologies and practice models of acupuncture, other CAMs and biomedicine. Increased interdisciplinary cooperation and communication is suggested as a means to improve patient safety and satisfaction and as a scenario for moving forward with IM.

1. THE PROBLEM

1.1 Introduction

The use of Complementary and Alternative Medicine (CAM) is now widespread (Ernst, 2000) with increasing endeavours being made to incorporate CAM into conventional healthcare and move towards Integrative Medicine (IM) (Johnson, Ward, Knutson, & Sendelback, 2012). Yet no roadmap exists to guide this process. New Zealand is in a situation similar to countries like the United States where 'health care must now catch up with consumer practices to provide guidance [for its] safe and effective use' (Wyatt & Post-White, 2005, p. 215).

Research interest has focused extensively on ascertaining both the prevalence of CAM use and analysing its efficacy and safety (Lewith, Jonas, & Walach, 2011; Low, 2004). One aspect less well understood is how patients experience specific forms of CAM (Low, 2004) and their reasons for using them. This is a particularly salient topic in the New Zealand context where public satisfaction is generally high within the comprehensive and largely publicly funded health system (Zwier, 2009) and where CAM is for the most part funded by out-of-pocket payment (OPP) by the user. Despite the financial disincentives for consumers considering CAM, it is used extensively and increasingly in parallel with global trends.

CAM is a diverse field and the theoretical frameworks; therapeutic techniques employed; and practitioner training and regulation vary considerably across modalities. Despite this diversity it has been argued that various CAMs share mutually referential ideologies (Montgomery, 1993; Coulter, 2004) and that people using them are motivated to do so by specific health beliefs (Furnham & Kirkcaldy, 1996). This study seeks to investigate acupuncture

specifically as a form of CAM, synthesise patients' experiences, and provide some insights into how their health beliefs influence usage.

Acupuncture is a CAM therapy of relevance in the New Zealand context in that (1) while it lies outside the biomedical health system, it is relatively well regulated and organised (there are two main registration boards for acupuncture requiring a standardised level of training, though membership remains voluntary); (2) it is considered by New Zealand General Practitioners (GPs) to be more “conventional” than other CAM therapies (Poynton, Dowell, Dew, & Egan, 2006); (3) is the most widely used CAM by doctors themselves (and probably other health professionals such as physiotherapists and midwives in New Zealand) (MACCAH, 2004); (4) and it is a modality that receives some public funding through the Accident Compensation Corporation (ACC)—a state sponsored corporation that provides injury insurance for people living in NZ—therefore broadening the socioeconomic demographic able to access the therapy, at least for a limited number of conditions.

Around 2-3% of adults use acupuncture at least once in a given year in New Zealand (MACCAH, 2004). This number is likely to rise since younger doctors tend to have more positive attitudes towards CAM and are more likely to refer to CAM practitioners (MACCAH, 2004). Additionally, people of Asian ethnicity are predicted to make up a greater proportion of the New Zealand population in the next decade (Ministry of Social Development, 2010) and this group tends to use acupuncture more than other ethnicities (ACC, 2011; Upchurch et al., 2008).

1.2 Research question

What are patients' perceptions and experiences of acupuncture, and how do personal health beliefs influence its use?

1.3 Purpose

- To synthesise the experiences of people receiving acupuncture
- To identify their health beliefs
- To identify how beliefs influence their use of acupuncture

1.4 My interest in the topic and pre-understandings

I am a thirty-five-year-old New Zealander of English birth and upbringing. My experiences of illness as a child engendered in me a profound wish to understand and improve my own health, and later led me to pursue a career in healing.

My interest in acupuncture was initially piqued through training in the martial arts where I was exposed to “Eastern” philosophy and healing systems. After completing an undergraduate degree in Health and Physical Education, I went on to study acupuncture and Chinese medicine at the Christchurch College of Holistic Healing. During my training, I became cognisant of the dissonance between biomedical and traditional Chinese conceptions of health. Once qualified as a practitioner I grew curious how patients reconciled these conflicting ideas within the context of their own healthcare. This study seeks to place the patient—the person—at the centre of inquiry and tries to understand their experiences, perceptions and how these relate to their choices of healthcare.

1.5 Chapter summary

This chapter has introduced the topic of interest, described some of the gaps in knowledge that exist, particularly that of patients' experiences and perspectives.

I have outlined my interest in the topic and illustrated my pre-understandings as a researcher.

2. REVIEW OF THE RELATED LITERATURE AND RESEARCH

2.1 Introduction

This chapter provides some background to the topic of interest initially by defining CAM and situating acupuncture within this definition. It offers an overview of safety and efficacy and describes the state of acupuncture practice, training and regulation in New Zealand with which to contextualise the study. Finally it presents the results of a qualitative systematic review of patients' experiences of acupuncture, which was undertaken in order to inform the main body of research in this thesis.

2.2 Situating acupuncture as a CAM

In many respects definitions of CAM are rather arbitrary, dependant on whom you are asking (Lewith et al., 2011, p. 5), and indeed how you ask (Fennell, Liberato, & Zsembik, 2009). Most often, theoretical criteria are used to characterise CAM as 'a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine' (NIH, 2013). In light of such criteria, acupuncture's position can be rather ambiguous in that it is practiced both within biomedicine (Diehl, Kaplan, Coulter, Glik, & Hurwitz, 1997; Leake & Broderick, 1999) and as a CAM in its own right.

This study interprets patients' experiences of acupuncture practiced within the context of a Chinese medical model and as such is considered CAM on the basis that it is an "alternative medical system" (see Table 1). This distinction is made to differentiate acupuncture as a discrete *technique* used within a

biomedical framework. Undoubtedly such a clear-cut division is an oversimplification but serves to contextualise the research.

Table 1
Types of CAM

Group 1: Alternative medical systems	Examples
Involve complete systems of theory and practice that evolved independently of, and often prior to, the biomedical approach. Many are traditional systems of medicine that are practised by individual cultures throughout the world.	Ayurveda Traditional Chinese medicine Pacific traditional healing systems Homoeopathy Naturopathy
Group 2: Mind / body / spirit interventions	
Employ a variety of techniques designed to facilitate healing. Only a subset of mind–body interventions are considered CAM. Those that have now had a well-documented theoretical basis (for example, patient education and cognitive-behavioural approaches) are considered ‘mainstream’.	Hypnotherapy Rebirthing Spiritual healing
Group 3: Biological-based therapies	
Involve natural and biologically based practices, interventions and products, many of which overlap with biomedicine’s use of dietary supplements.	Herbal medicine Homeobotanical therapy Biological therapies
Group 4: Manipulative and body-based therapies	
Involve methods based on manipulation and/or movement of the body.	Chiropractic Osteopathy Massage (therapeutic and remedial) Alexander technique
Group 5: Energy therapies	
Focus on the energy fields originating from within the body (biofields) or those from other sources (electromagnetic fields).	Qìgōng Reiki Touch for health Bioelectromagnetic-based therapies

(Note. Adapted from MACCAH. (2004). *Complementary and alternative health care in New Zealand: Advice to the Minister of Health from the Ministerial Advisory Committee on complementary and alternative health*. Wellington, N.Z: Ministerial Advisory Committee on Complementary and Alternative Health.)

2.3 Acupuncture in New Zealand

A number of factors make it difficult to be precise about the extent of acupuncture usage within New Zealand, but it has been estimated that approximately 2-3% of adults visit an acupuncturist in a given year (MACCAH, 2004; Pledger, Cumming, & Burnette, 2010) with the number of registered traditionally trained acupuncturists around 650 (NZASA, 2013; NZRA, 2012).

Traditional acupuncturists in New Zealand usually complete the National Diploma of Acupuncture (NDA) over three to four years of full-time study. Practitioners can register with one of two organisations, the New Zealand Register of Acupuncturists (NZRA) or the New Zealand Acupuncture Standards Authority (NZASA). The NZRA is currently the largest professional body representing traditional acupuncturists and Chinese herbalists in New Zealand, with a membership of about 400 practitioners (NZRA, 2012). Acupuncturists may register with the NZRA upon completion of the NDA or, having qualified overseas, sat and passed an entry examination. Members are required to complete on-going professional education in order to maintain their Annual Practicing Certificate (NZRA, 2012). The NZASA is a similar registration authority established more recently and like the NZRA is a member-led organisation with a nominated Executive. (NZASA, 2011) To register, practitioners must either hold the NDA (or equivalent) or be a practicing health professional with a post-graduate qualification in acupuncture at Level 8 or above (1200 hours), or equivalent (NZASA, 2011). There are around 250 practitioners listed on the NZASA register.

While statutory regulation has been recommended for a more rigorous process to ensure public safety (Smith, 2010), currently the relevant legislation—the Health Practitioners Competency Assurance Act (HPCAA) (2003)—is not applicable to traditional acupuncturists, and membership of either the NZRA or NZASA organisation remains voluntary.

Registered acupuncturists can provide services for approved claims with funding from state insurer, ACC. This coverage relates to a limited number of musculoskeletal conditions (see Appendix I). Some private health insurance plans also cover a limited amount of acupuncture while patients themselves fund a significant proportion of treatment through out-of-pocket payment (OPP).

2.4 Safety and efficacy of acupuncture

2.4.1 Safety

As acupuncture usage has increased in the West, coupled with recent pushes for evidence-based practice (EBP), safety has become an increasingly important issue (MacPherson, White, & Bensoussan, 2007). In general, the risks associated with acupuncture fall within two categories: those associated with the techniques of acupuncture itself and those related to the judgment of the practitioner. On this basis, Bensoussan and Myers (1996) developed a schema for classification of risk in acupuncture treatment (see Table 2).

Table 2 <i>Classification of Risk in Acupuncture Practice</i>		
Category of risk	Area of risk	Principal types
Acupuncture	Reactions related to needling	Cross infection Trauma Physiological responses Metal allergy Idiosyncratic reactions
Clinical judgment of the acupuncturist	Commission	Incorrect treatment Advice to forgo conventional therapy Misdiagnosis leading to delayed conventional treatment
	Omission	Failure to refer Failure to explain risks

(Note. Adapted from Bensoussan, A., & Myers, S. P. (1996). Towards a safer choice: *The practice of traditional Chinese medicine in Australia*.)

Accurately assessing the risk for any medical intervention can be challenging, particularly when practice precedes clinical trials, and when practitioners are poorly integrated with health systems and their reporting systems. Both retrospective (Abbot, Hill, Barnes, Hourigan, & Ernst, 1998; Bensoussan, Myers, & Carlton, 2000; F. Chen, Hwang, Lee, Yang, & Chung, 1990; Norheim & Fønnebø, 2000; Yamashita, Tsukayama, Tanno, & Nishijo, 1998) and prospective surveys (MacPherson, Thomas, Walters, & Fitter, 2001; White, Hayhoe, Hart, & Ernst, 2001; Yamashita, Tsukayama, Tanno, & Nishijo, 1999) have assessed acupuncture use in different countries and calculated the incidence of specific adverse events. Taken within the context of a broader body of knowledge, such studies have led to a consensus that acupuncture is generally very safe when delivered by properly trained practitioners (Adams et al., 2011;

Kennedy & Beckert, 2010; Vincent, 2001; White, 2006; Xu et al., 2013). Adverse events are usually minor or transient (Melchart et al., 2004) and serious complications extraordinarily rare, usually resulting from insufficient training and improper technique (Norheim, 1996; Norheim & Fonnebo, 1996; Zhang, Shang, Gao, & Ernst, 2010).

2.4.2 Efficacy

In order to provide an overview of the efficacy of acupuncture the Cochrane database was searched for all systematic reviews involving its use. The summary of this search, presented in Table 3, shows that acupuncture interventions have been found to be efficacious for a small number of neurological and gastrointestinal disorders, (specifically migraines, tension-type headaches, and chemotherapy-induced acute vomiting). There is moderate or tentative evidence to support a broader range of conditions, while the majority of reviews to date have either been inconclusive or found insufficient evidence. Whereas this provides a general overview of the evidence as it stands, the suitability of current methodologies is contentious and the research issues surrounding acupuncture complex. There is 'almost unanimous agreement that controlled clinical trials of acupuncture have suffered from multiple flaws' (Birch, 2004, p. 481) and that current methods need revision. For the time being however, these conclusions have been synthesised from the evidence as it stands.

Table 3 <i>Cochrane Reviews of Acupuncture Interventions</i>		
Condition/Title of review (Authors)	Trials/participants included in review	Conclusions
Acupuncture for cancer pain in adults (Paley, Johnson, Tashani, & Bagnall, 2011)	Three RCTs/204 participants	Insufficient evidence
Acupuncture for peripheral joint osteoarthritis (Manheimer et al., 2010)	16 trials/3498 patients	Moderate evidence
Acupuncture for treatment of irritable bowel syndrome (Manheimer et al., 2012)	17 RCTs/1806 participants	Inconclusive
Acupuncture for migraine prophylaxis (Linde et al., 2009a)	22 trials/4419 participants	Positive evidence
Tension-type headache (Linde et al., 2009b)	11 trials/2317 participants	Positive evidence
Acupuncture for shoulder pain (Green, Buchbinder, & Hetrick, 2005)	Nine trials	Inconclusive
Acupuncture for depression (Smith, Hay & MacPherson, 2010)	30 trials/2812 participants	Insufficient evidence
Acupuncture for Autism Spectrum Disorders (ASD) (Cheuk, Wong, & Chen, 2011)	10 trials/390 children	Inconclusive

Acupuncture for acute management and rehabilitation of traumatic brain injury (Wong, Cheuk, Lee, & Chu, 2013)	Four RCTs/294 participants	Inconclusive
Auricular acupuncture for cocaine dependence (Gates, Smith Lesley, & Foxcroft, 2006)	Seven studies/1433 participants	Inconclusive
Acupuncture and electroacupuncture for the treatment of rheumatoid arthritis (Casimiro et al., 2005)	Two studies/84 participants	Insufficient evidence
Acupuncture for neck disorders (Trinh et al., 2006)	10 trials	Moderate evidence
Acupuncture for acute stroke (Zhang, Liu, Asplund, & Li, 2005)	14 trials/1208 patients	Inconclusive
Acupuncture for schizophrenia (Rathbone & Xia, 2005)	Five trials	Insufficient evidence
Mumps in children (He, Zheng, Zhang, & Jiang, 2012)	One study/239 participants	Inconclusive
Acupuncture for Attention Deficit Hyperactivity Disorder (ADHD) in children and adolescents (Li et al., 2011)	No studies met the inclusion criteria	Insufficient evidence
Acupuncture for insomnia (Cheuk, Yeung, Chung, & Wong, 2012)	33 trials/2293 participants	Inconclusive
Acupuncture for dysphagia in acute stroke (Xie, Wang, He, & Wu, 2008)	One trial/66 participants	Insufficient evidence
Acupuncture for Restless Legs Syndrome (Cui, Wang, & Liu, 2008)	Two trials/170 patients	Insufficient evidence
Acupuncture for chronic asthma (McCarney, Brinkhaus,	12 studies/350	Insufficient evidence

Lasserson, & Linde, 2003)	participants	
Acupuncture for vascular dementia (Peng, Wang, Zhang, & Liang, 2007)	No studies met the inclusion criteria	Insufficient evidence
Acupuncture for slowing the progression of myopia in children and adolescents (Wei, Liu, Li, & Liu, 2011)	Two trials/131 participants	Inconclusive
Acupuncture for Bell's palsy (Chen, Zhou, He, Zhou, & Li, 2010)	Six trials/537 participants	Insufficient evidence
Acupuncture and dry-needling for low back pain (Furlan Andrea et al., 2005)	35 trials	Moderate evidence
Acupuncture and assisted conception (Cheong, Hung, & Ledger, 2008)	13 trials	Moderate evidence (acupuncture performed on the day of embryo transfer shows a beneficial effect on the live birth rate)
Acupuncture for stroke rehabilitation (Wu Hong et al., 2006)	Five trials/368 participants	Insufficient evidence
Acupuncture and related interventions for smoking cessation (Cheng, 2011)	33 reports of studies	Inconclusive
Acupuncture for pain in endometriosis (Zhu, Hamilton Kindreth, & McNicol, 2011)	One trial/67 participants	Insufficient evidence
Acupuncture or acupressure for pain management in labour (Smith, Collins, Crowther, & Levett, 2011)	13 trials/1986 participants	Moderate evidence (reducing pain, increasing satisfaction with pain management and reduced use of pharmacological management)

Acupuncture-point stimulation for chemotherapy-induced nausea or vomiting (Ezzo et al., 2005)	11 studies/1247 participants	Positive evidence (electroacupuncture has demonstrated benefit for chemotherapy-induced acute vomiting)
Acupuncture for dysmenorrhoea (Smith, Zhu, He, & Song, 2011)	10 trials/944 participants	Moderate evidence
Acupuncture for uterine fibroids (Zhang, Peng, Clarke, & Zhishun, 2010)	No RCTs met the inclusion criteria	Insufficient evidence
Acupuncture for lateral elbow pain (Green et al., 2002)	Four small RCTs	Insufficient evidence
Cephalic version by moxibustion for breech presentation (Coyle, Smith, & Peat, 2012)	Eight trials/1346 participants	Moderate evidence (limited evidence to support the use of moxibustion for correcting breech presentation. There is some evidence to suggest that the use of moxibustion may reduce the need for oxytocin. When combined with acupuncture, moxibustion may result in fewer births by caesarean section; and when combined with postural management techniques may reduce the number of non-cephalic presentations at birth)
Acupuncture for glaucoma (Law Simon & Li, 2007)	No RCTs	Insufficient evidence
Acupuncture for induction of labour (Smith & Crowther 2004)	Three trials/212 participants	Insufficient evidence

Acupuncture for Polycystic Ovary Syndrome (PCOS) (Lim Danforn et al., 2011)	No truly randomised controlled trials of acupuncture for PCOS were found	Insufficient evidence
Acupuncture for epilepsy (Cheuk & Wong, 2008)	16 trials/1486 participants	Insufficient evidence
Acupuncture for the treatment of postoperative nausea and vomiting (Manheimer, Eaton, Lao, White, & Morozova, 2013)	40 trials/4858 participants	Moderate evidence (P6 point stimulation comparable to antiemetic drugs)
CAM therapies for pain management in labour (Smith, Collins, Cyna, & Crowther, 2006)	14 trials/1537	Moderate evidence (acupuncture and hypnosis may be beneficial for the management of pain during labour)
Interventions (other than pharmacological, psychosocial or psychological) for treating antenatal depression (Dennis & Allen, 2008)	One three-armed RCT/61 participants	Inconclusive
Pain management for women in labour (an overview of systematic reviews) (Jones et al., 2012)	15 Cochrane reviews (255 included trials) and three non-Cochrane reviews (55 included trials)	Moderate (fewer assisted vaginal births and caesarean sections and may improve management of labour pain, with few adverse effects when compared with placebo or standard care)
Complementary and miscellaneous interventions for nocturnal enuresis in children (Huang, Shu, Huang, & Cheuk, 2011)	24 trials/1283 participants	Weak evidence

Interventions for nausea and vomiting in early pregnancy (Matthews, Dowswell, Haas, Doyle, & O'Mathúna, 2010)	27 trials/4041 participants	Inconclusive (difficulties in interpreting the results)
Breast engorgement during lactation (Mangesi & Dowswell, 2010)	Eight studies/744 participants	Inconclusive (receiving acupuncture had greater improvements in symptoms in the days following treatment, although there was no evidence of a difference between groups by six days)
Physical therapy for Bell's palsy (idiopathic facial paralysis)[including acupuncture] (Teixeira Lázaro, Valbuza, & Prado, 2011)	Twelve studies met the inclusion criteria (872 participants)	Inconclusive (acupuncture studies did not provide useful data as all were short and at high risk of bias)
Non-hormonal interventions for hot flushes in women with a history of breast cancer (Rada et al., 2010)	Two trials (specifically assessing acupuncture)	Inconclusive
Non-pharmacological interventions for assisting the induction of anaesthesia in children (Yip, Middleton, Cyna, & Carlyle, 2009)	17 trials/1796 participants	Moderate evidence (children of parents having acupuncture compared with parental sham-acupuncture were less anxious during induction (mYPAS MD 17, 95% CI 3.49 to 30.51) and more children were co-operative (RR 0.63, 95% CI 0.4 to 0.99). Parental anxiety was also significantly reduced in this trial)
Interventions for preventing and treating pelvic and back pain in pregnancy (Pennick & Young, 2007)	Eight studies/1305 participants	Moderate (acupuncture shows better results compared to physiotherapy but moderate to high potential for bias, so results must be viewed cautiously)

Non-pharmacological interventions for breathlessness in advanced stages of malignant and non-malignant diseases (Bausewein, Booth, Gysels, & Higginson, 2008)	47 studies/2532 participants (specifically assessing acupuncture)	Weak evidence (there is a low strength of evidence that acupuncture/acupressure is helpful)
Different methods for the induction of labour in outpatient settings (Dowswell, Kelly, Livio, Norman, & Alfirevic, 2010)	28 studies/2616 participants	Insufficient evidence
Acupuncture for subacute non-specific low-back pain (Furlan et al., 2011)	13 RCTs	Moderate (the evidence suggests that acupuncture massage is more effective than classic massage)
Interventions for dysphagia and nutritional support in acute and subacute stroke (Geeganage, Beavan, Ellender, & Bath, 2012)	33 studies/6779 participants	Moderate
Urinary incontinence after stroke in adults (Thomas et al., 2008)	12 trials/724 participants	Insufficient evidence
Non-surgical treatment (other than steroid injection) for carpal tunnel syndrome (O'Connor, Marshall, Massy-Westropp, & Pitt, 2003)	21 trials/884 participants (the number receiving acupuncture was not stated)	Insufficient evidence
Physical medicine modalities for mechanical neck disorders (Gross, Aker, Goldsmith Charles, & Peloso Paul Michael, 1998)	13 trials included (the number receiving acupuncture was not stated)	Inconclusive

Conscious sedation and analgesia for oocyte retrieval during in vitro fertilisation procedures (Kwan, Bhattacharya, Knox, & McNeil, 2013)	12 papers (considerable heterogeneity of interventions)	Insufficient evidence
Transcutaneous electrical nerve stimulation and acupuncture-like transcutaneous electrical nerve stimulation for chronic low back pain (Gadsby & Flowerdew, 2006)	Six papers	Moderate

2.5 Qualitative systematic review of acupuncture patients' experiences

To establish what has already been identified in the literature and to help shape the research question, I conducted a qualitative systematic review. This review focused primarily on the experiences and health beliefs of patients receiving traditional acupuncture.

2.5.1 Search methods

After reviewing the Medical Subject Headings (MeSH) scope notes for relevant search terms (see Appendix A), five electronic health and medical databases (CINAHL, PubMed, Ovid Medline, ISI Web of Science, and PsychINFO) were searched without specifying date limits (see Table 4). For inclusion in the current review, the evidence had to fulfil the criteria below. These criteria were developed *a priori*:

- Published in English language
- Qualitative or mixed methodology
- Presenting an analysis of adult patients' experiences of acupuncture

The reference lists of included papers were hand searched to identify any peer-reviewed literature that may have been missed in the electronic database literature search.

Table 4
Search Strategy

Database (Date Searched)	Term 1 (Field)	Term 2 (Field) Combined with AND	Term 3 (Field) Combined with AND
CINAHL (18/3/2012)	Health beliefs Qualitative studies Experiences	Acupuncture	Alternative therapies
PubMed (18/3/2013)	Attitude to health Qualitative research Experiences	Acupuncture	Complementary therapies
PsychINFO (18/3/2013)	Health attitudes Qualitative research Experiences	Acupuncture	Alternative medicine
ISI (18/3/2013)	Health beliefs Qualitative research Experiences	Acupuncture	Complementary therapies
MEDLINE (18/3/2013)	Attitude to health Qualitative research Experiences (keyword)	Acupuncture	Complementary therapies

2.5.2 Search outcome

Studies were selected for appraisal using a two-stage process. First, titles and abstracts (where available) identified from the search strategy were scanned and excluded as appropriate. Second, the full text articles were retrieved for the remaining studies and selected for inclusion and appraisal in the review if they fulfilled the selection criteria.

The search generated 771 results after removal of duplications. Reviewing the abstracts found 757 articles did not appear to meet the selection criteria (see Table 5). The remaining 14 studies originating in the UK, Norway, Sweden, Australia, and the US were published between 1998 and 2012 and comprised exclusively qualitative as well as mixed methods studies (see Table 6).

Table 5 <i>Search Outcome</i>	
Exclusion criteria	Number
Total citations	771
Title and abstract reviewed (first pass)	
<ul style="list-style-type: none">• Not specifically related to acupuncture• Not in English	644
Full text reviewed (second pass)	127
<ul style="list-style-type: none">• Wrong participants group (e.g. not adult patients)• Full publication unavailable• Qualitative methodology not used	113
Full papers reviewed	14
Total included for quality appraisal	14

2.5.3 Quality appraisal

The aim of this review was to find the highest quality evidence to inform the research question. The selected studies were assessed for quality using the validated ten-point checklist from the Joanna Briggs Institute (JBI) Qualitative Assessment and Review Instrument (QARI) (Joanna Briggs JBI, 2010). Although several of the articles did not fulfil all the quality criteria in the QARI tool, omissions were minor or reflected their date of publication so all were included in the review (see Table 7).

Table 6

Summary of Qualitative Studies Examining Patients' Experiences of Acupuncture

Study	Method	Phenomena of interest	Sample and Setting
(Asprey, Paterson, & White, 2012)	Phenomenology	The acceptability and perceived advantages and disadvantages of acupuncture delivered in the group setting for the treatment of knee osteoarthritis (OA)	Purposive sample of patients and all the acupuncture nurses, Royal London Hospital for Integrated Medicine, and in primary care in St Albans, Hertfordshire, UK
(Alraek & Baerheim, 2001)	Giorgi's phenomenological approach	To explore changes in health as reported by cystitis-prone women after having received prophylactic acupuncture treatment for recurrent cystitis	46 women in Norwegian acupuncture RCT
(Alraek & Malterud, 2009)	'Systematic text condensation'	Changes in health experienced by postmenopausal women after having acupuncture treatment for hot flashes	Participants in Norwegian RCT, where 134 women had been randomised to acupuncture treatment
(Griffiths & Taylor, 2005)	Van Manen's approach	To describe the lived experience of acupuncture treatment, with specific objectives to: inform nurses of people's experiences of having acupuncture	12 participants (7 male, 5 females, age range of 25–55 years), NSW, Australia
(Paterson & Britten, 2004)	Grounded Theory	Investigate how the experience, and the effects, of a course of acupuncture evolved over time	Consecutive sample of 23 people with chronic illness, who were having acupuncture for the first time, Bristol, UK

(Paterson & Britten, 2003)	Grounded Theory	To what extent do three subjective health questionnaires encompass and measure treatment effects of acupuncture	23 people with chronic illness, who were having acupuncture for the first time, Bristol, UK
(Paterson & Britten, 2008)	Grounded Theory	The diverse nature of peoples' experiences of acupuncture treatment for chronic health problems and an analysis of holism	Secondary analysis of five longitudinal interview studies, a variety of settings in the UK and Australia
(Hughes, 2009)	Grounded Theory	Rheumatoid arthritis (RA) patients' experiences of receiving treatment with acupuncture	Convenience sample of thirteen patients with RA receiving acupuncture in the northwest of England
(Bishop, Barlow, Coghlan, Lee, & Lewith, 2011)	'Inductive thematic analysis'	To compare patients' experiences of public and private sector healthcare, using acupuncture as an example	Purposive sample of 27 patients who had recently used acupuncture for painful conditions in the private sector and/or in the National Health Service (NHS) in the UK
(Billhult & Stener-Victorin, 2012)	Giorgi's phenomenological approach	The experience of acupuncture for women diagnosed with Polycystic Ovarian Syndrome (PCOS)	Eight Swedish women who had previously participated in a RCT using acupuncture
(Cassidy, 1998)	Mixed	To determine what users of Chinese Medicine think the care does for them, or why they value and 'like' the care	Sample of 460 handwritten stories collected as part of a mixed quantitative qualitative survey of six acupuncture clinics in five U.S. states

(Paterson, 2007)	Not explicitly stated, possibly phenomenology	Patients' perspectives of the process and outcome of Western-style acupuncture for chronic health problems	Purposive sample of 18 patients receiving acupuncture in Bristol, Somerset and Wiltshire, UK
(Rugg, Paterson, Britten, Bridges, & Griffiths, 2011)	'Longitudinal qualitative study'	To ascertain how patients with Medically Unexplained Physical Symptoms (MUPS) perceive and experience five-element acupuncture treatment	Purposive sample of 20 trial participants in a longitudinal qualitative interview study, nested in a randomised controlled trial carried out in four general practices in socioeconomically diverse areas of London, UK
(Gould & MacPherson, 2001)	Mixed	To determine patients' experience of outcomes after acupuncture treatment	11 patients of acupuncture practices in York, England

Table 7 <i>Quality Appraisal of Studies</i>												
Study	Methodology	1	2	3	4	5	6	7	8	9	10	Score
Asprey et al., 2012	Not explicitly stated (Phenomenology?)	?	Y	Y	Y	Y	N	Y	Y	Y	Y	8
Alraek & Baerheim, 2001	Giorgi's phenomenological approach	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Alraek & Malterud, 2009	'Systematic text condensation'	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Hughes, 2009	Grounded Theory	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Griffiths & Taylor, 2005	Van Maanen's approach	Y	Y	Y	Y	Y	?	?	Y	Y	Y	8
Paterson & Britten, 2004	Grounded Theory	Y	Y	Y	Y	Y	?	N	Y	N	Y	7
Paterson & Britten, 2003	Grounded Theory	Y	Y	Y	Y	Y	N	Y	Y	N	Y	8
Paterson & Britten, 2008	Grounded Theory	Y	Y	Y	Y	Y	N	N	Y	N	Y	7
Billhult & Stener-Victorin, 2012	Giorgi's phenomenological approach	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	9
Cassidy, 1998 (part 2)	Not explicitly stated (Phenomenology?)	N	Y	Y	Y	Y	N	N	Y	N	Y	6
Bishop et al., 2011	'Inductive thematic analysis'	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Patterson, 2007	Not stated, (Phenomenology?)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Rugg et al., 2011	'Longitudinal qualitative study'	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9
Gould & MacPherson, 2001	Mixed Method	Y	?	Y	?	?	N	N	Y	Y	Y	5

Key for Table 7:

1. There is congruity between the stated philosophical perspective and research methodology.
2. There is congruity between the research methodology and the research question or objectives.
3. There is congruity between the research methodology and the methods used to collect data.
4. There is congruity between the research methodology and the representation and analysis of data.
5. There is congruity between the research methodology and the interpretation of results.
6. There is a statement locating the researcher culturally or theoretically.
7. The influence of the researcher on the research, and vice-versa, is addressed.
8. Participants and their voices are adequately represented.
9. The research is ethical according to current criteria, or for recent studies, there is evidence of ethical approval by an appropriate body.
10. Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.

2.5.4 Data abstraction and synthesis

All direct quotes from patient participants were extracted from the studies. Excerpts were analysed thematically, assigned categories and sub-codes, and annotated using a constant comparison methodology. The Dedoose tool (Weisner & Lieber, 2013) was used for data management and analysis, as the only proprietary software package compatible with the computer operating system being used. The web-based platform also facilitated access from multiple locations. From the categories developed, four overarching themes were identified: reasons for using acupuncture, treatment experiences, treatment outcomes, and therapeutic model.

2.5.5 Results

Reasons for use

Patients often contextualised their experiences by explaining their reasons for using acupuncture. Two main sub-categories were identified: i. dissatisfaction with conventional care and ii. specific health beliefs.

i. Dissatisfaction with Conventional Care

In contrast to other studies of CAM, which have identified *push factors* (elements of dissatisfaction that push patients away from biomedicine) as a significant motivating factor for patients, this appeared to be a relatively minor dynamic in this review, though several patients did describe some level of dissatisfaction with biomedicine as a catalyst for initially trying acupuncture. This dissatisfaction, where it was expressed, was related to lack of success with biomedicine, adverse effects (iatrogenic infections, for example) or what was perceived as a 'fragmented symptoms approach' (Cassidy, 1998, p. 199).

Given that many of the study participants were seeking treatment for chronic, difficult to treat health conditions (rheumatoid arthritis for example), it is perhaps unsurprising that they expressed limited improvements from conventional medical treatment. One participant, related, 'I've tried the medical side of things and that either hasn't helped or the side effects that I'm now aware of, now lead me towards alternative therapy and acupuncture' (Griffiths & Taylor, 2005, p. 114). Using acupuncture as a treatment option was not exclusively patient driven and in some instances, medical practitioners had recommended acupuncture when conventional options had been exhausted.

Reasons for continuing to use acupuncture changed with continuing treatment. Some participants who experienced alleviation of the symptoms of their initial presenting complaint went on to use acupuncture for other ailments, either in a continuing course of treatment, or as a new course of treatment at a later date.

Adverse events as a push factor were identified fairly frequently, with surgical infections and drug side effects as the most common complaints. Many patients described reduction in their medication as a significant perceived benefit of acupuncture:

I had a Grand Mal seizure in 1989... no reoccurrence for 3 months but my [medical] doctor insisted I take Dilantin in a very high dosage [which] caused my hand to tremor... exacerbated my liver disease and periodontal disease. In 1991 I began seeing an acupuncturist. With acupuncture, herbs, meditation, dietary changes, and improved oral hygiene... I eventually got off my anti-seizure meds entirely. My gums have improved and my liver is greatly improved. (Cassidy, 1998, p. 196)

Symptomatic treatment as a cause for dissatisfaction with biomedicine often related to concern that the root of the problem had not been addressed, 'I don't just believe in killing pain, [I] knew there was something deeper' (Gould & MacPherson, 2001, p. 265). Generally participants tended to describe themselves as pragmatic consumers seeking relief from complaints that had not been satisfactorily treated elsewhere.

ii. Specific Health Beliefs

Several studies (Cassidy, 1998; Gould & MacPherson, 2001; Griffiths & Taylor, 2005; Paterson & Britten, 2003) depicted patients' health beliefs as a significant factor in their use of acupuncture. Participants were often not familiar with Chinese medicine theory or philosophy per se (at least at the beginning of treatment) but tended to relate positively to a holistic approach based on their experiences, implying that Chinese medicine practice closely reflects its philosophical underpinnings:

I especially appreciate being looked at as a whole being, mind and spirit as well as body, and one body as opposed to separate parts... Acupuncture has improved my health from a holistic viewpoint—not just a fragmented symptoms approach. (Cassidy, 1998, p. 199)

Patient education often played a significant part of acupuncture treatment. Participants described learning about Chinese medicine philosophy, using specific terminology such as yīn/yáng, meridians, qì etc. to describe their condition and experiences. Some patients went further, aligning themselves with the spiritual/metaphysical dimensions of Chinese medicine more explicitly:

I don't know that much about it, about the whole paradigm, but from what I do know, it makes sense to me. I believe that there is an energetic system within the body and within the planet and that we are all a part of one big thing, so yes, it makes sense to me. (Griffiths & Taylor, 2005, p. 114)

The Bishop et al. (2011) study suggested that perception of acupuncture, as a holistic modality might be a product of health system factors, as much as paradigmatic differences between Chinese and biomedicine. In this study, patients who had received both private sector and publically funded acupuncture, characterised private sector treatment as holistic and individualised (resonating with their health beliefs) versus what was sometimes seen as impersonal or institutionalised treatment within the public health system. This view was not necessarily corroborated in other studies however. Participants in the Hughes (2009) study received either Western or Traditional Chinese Medicine (TCM) acupuncture, both in a private sector setting, and tended to interpret Western acupuncture predominantly as a medical procedure (i.e. the needling process) whereas TCM acupuncture was understood to be more encompassing with greater emphasis on the whole treatment process as well as the patient-practitioner relationship.

Treatment experiences

Descriptions of the treatment process fell into three categories: i. Diagnosis/intake, ii. Explaining treatment, and iii. Sensations during treatment.

i. Diagnosis/intake

The intake process (i.e. the initial consultation process) was generally referred to as being very thorough, and participants often expressed surprise at

the depth of questioning that their acupuncturists went into, 'The first time I saw Jo [acupuncturist] I was amazed, because she took down an entire case history. She asked questions about every aspect, which must have taken over an hour' (Paterson & Britten, 2008, p. 268). This detailed intake process played an integral part in the therapeutic experience.

Boundaries between intake and treatment could become blurred, implying a counselling-like dynamic, 'She was the first person that I'd told the whole story to. It felt like I was telling her everything and letting her take the burden for a bit, as if I had given it all to her' (Paterson & Britten, 2008, p. 268). Similarly in Rugg (2011), 'I feel [the intake interaction is] a really positive thing; it felt like it was part, part of the healing process' (p. 309). Acupuncture in these studies was experienced as a therapeutic system that is not, as Cassidy's (2009) study suggests, necessarily predicated simply on the strategic insertion of needles at acupoints.

The different diagnostic criteria used by traditional acupuncturists appeared to be a prominent feature in participants' awareness. Reference was frequently made to the use of traditional tongue and pulse diagnosis methods, with some participants expressing incredulity at the accuracy of practitioners' analyses:

He just looks, he looks at your tongue, takes your pulse and then he tells you. Which is, it's incredible. I'm simply in awe of the whole thing because I think he could probably tell me what I had for lunch before long! (Paterson & Britten, 2004, p. 797)

Diagnostics were not restricted exclusively to traditional methods however and some patients referred to practitioners' reliance on biomedical instruments such as x-rays and blood tests as well.

Just as structural factors influenced patients' perceptions of whether acupuncture represented a holistic form of treatment or not, they also appear to have influenced patients' experiences of the intake process. Several studies noted the differences between intake processes in private versus public health settings. Participants who had received acupuncture both privately and publically in the UK for example, made comparisons, noting that the intake process in the private sector was more thorough.

ii. Explaining treatment

Explanation of treatment featured moderately in patients' experiences. Possibly because Chinese medicine is a relatively unfamiliar paradigm for most Western patients, practitioners went to greater lengths to explain treatment than might be expected from biomedical practitioners. Explanations ranged from underlying theories to the application of techniques—'I did say to him, "why the wrists?" So, he [explained that acupuncture meridians are] like a circuit board, and, if you, sort of, plug a bit in here, then it's got to, sort of, ricochet somewhere or other' (Paterson & Britten, 2004, p. 797). Explanations elicited mixed responses; some participants appreciated the time taken and appeared to resonate with the explanation they were given while others clearly felt Chinese medicine lacked precision or conflicted with their own epistemological perspective:

I would have liked more opinion from him... Rather than saying, well it's just the whole thing out of balance a little bit, a bit more scientific but, you

know, I got the impression, you know, I was probably looking for a cut-and-dried answer and he was saying there are no cut-and-dried answers. (Paterson & Britten, 2004, p. 7)

iii. Physical sensations

Inserting acupuncture needles can produce a variety of sensations including those known as *dé qì* ('the arrival of qì). Obtaining this sensation is traditionally thought to be integral to successful therapy, particularly in the treatment of painful conditions (White, Prescott, & Lewith, 2010). Participants described their physical experiences during treatment often making direct reference to *dé qì* or analogous ideas such as "energy" or electricity moving, aching or diffuse sensations, 'I guess the energy, as she started to get to the correct point, it was like a dull ache. It was almost like a numbness in my arms. Going to sleep sort of numbness' (Griffiths & Taylor, 2005, p. 117). Some participants experienced pain during treatment though this was generally minor and transient.

A strong theme across most of the studies was a sense of relaxation or calmness during treatment, 'it was very relaxing, but not sleepy. Other people have come out and reported that they need a nap kind of thing, and many people fall asleep during their treatment. But I was relaxed and energized' (Griffiths & Taylor, 2005, p. 118).

Treatment Outcomes

Qualitative research nestled within RCTs included relatively homogeneous groups of participants receiving acupuncture for specific conditions, while stand-alone qualitative studies covered participants with a

wider range of presenting complaints. Patients' outcome experiences were correspondingly varied but could be described as either condition specific or non-condition specific, both groups of which had broader life impacts.

For participants in this review, condition-specific effects included pain reduction (including various joint pain, headaches, and migraines), other neurological changes such as reduction in dizziness, improvement in mobility (this may have been due to pain reduction), normalised blood pressure, immunological changes (including specific measures such as increased CD4 cell count), mental/emotional changes (e.g. less frequent mood swings), urinary system changes, reduction in gastrointestinal symptoms (nausea, reflux, etc.), vasomotor changes (reduction in frequency or severity of hot flushes in menopausal women) and for some, no observable changes at all.

Non-condition specific effects were common. These included physical and mental/emotional changes such as improved energy, better sleep, stress reduction and others.

Both condition-specific (such as pain reduction) and non-condition-specific outcomes (e.g. improved energy) had repercussions on the lives of many participants; for some these were significant. Those who experienced reduction in pain and improvement in mobility for example spoke of the accompanying improvement in their quality of life:

I'd got back to how I was before I started with the arthritis... I could see to the kids, I could play with them. I could like do my housework myself, I wasn't troubling anybody, I wasn't waiting for me mum to come. It just gave me a freedom, an independence again, because I was more able to do normal chores. Just normal everyday household things, like getting the kids

ready, making a breakfast, doing the dishes, even polishing their shoes... I felt more confident, [sic.] more on a par with everybody else, not different. I was independent. That makes you feel better in yourself. (Hughes, 2009, p. 272)

Others spoke of profound impacts relating to sense of self and worldview: 'Acupuncture totally changed my life, my attitude, outlook—so profoundly that I decided to study acupuncture and make it my life's work' (Cassidy, 1998, p. 198), and:

My treatments have always provided new information that was absent to me before. I would label my sessions as minor realizations—placing a framework around what I intuitively knew to be true... helped me to relate to myself and others much better and feel much more grounded ... and aware of myself. (Cassidy, 1998, p. 197)

Therapeutic model

The therapeutic model was an important aspect in people's experiences of acupuncture and was characterised by three main sub-themes: i. Holism, ii. Patient-practitioner relationship, and iii. Self-care and personal responsibility

i. Holism

The concept of holism (in contrast to reductionism) is that health relies on the balanced integration of all aspects of being: body, mind, spirit, social relationships and the wider environment (Coulter, 2004) and that the whole is greater than the sum of its parts. Holism is aptly compared to the theoretical underpinnings of Chinese medicine theory and appears to play a significant part in its practice:

I think she looks at you as, you know, as a whole person and how you're affected by your life and your work and your attitude to things, everything, yeah, I'm sure she's looking at you. Yes, as a whole person. (Paterson & Britten, 2004, p. 797)

Similarly in Cassidy (1998), 'He sees me as a whole person and I am also encouraged to help myself in various ways, e.g., exercise.' (p. 198).

The perception of holism in acupuncture experiences was frequently contrasted with previous health encounters (usually public sector biomedical care):

I found it more holistic than most western medicine, which does tend to just treat the problem, rather than look at it in the context you are in... I remember her sort of trying to get a view of me as a person, illnesses and I guess doing a patient history really before she got stuck into treating the problem, and all that took a little time... And she explained a bit about, in more detail, about what the Chinese philosophy was and what she was trying to do with [the acupuncture]. (Griffiths & Taylor, 2005, p. 114)

ii. Patient-practitioner relationship

Several studies conveyed the patient-practitioner relationship as distinctive and central to the therapeutic experience. Terms such as, 'non-judgmental', 'friendly', 'listening', and 'respect' were typical descriptions of practitioners' attributes. Locus of control in the therapeutic relationship was mostly perceived to be shared. In the preliminary quantitative survey of Cassidy's (1998) study, participants were asked to characterise the role of their practitioner by selecting among words representing a 'vertical' relationship (parent, teacher, doctor, authority, expert) or a 'horizontal' one (partner, friend,

guide, coach) The horizontal terms, were favoured by the majority (67%) of participants and of the vertical terms, only the term 'doctor' was common (mostly where the practitioner used this title).

iii. Self-care and personal responsibility

Relationships between patients and practitioners that are predominantly horizontal may be a significant factor that is used in promoting effective patient education, self-care, and personal responsibility.

Dietary and lifestyle recommendations often formed an integral part of treatment:

She...told me to come off of coffee and Diet Coke... I had drank around about four, five, in a morning. A few dinner time and then, at night, I had a couple of coffees. In between I was drinking bottles of Diet Coke. I feel better not drinking it, actually. (Rugg et al., 2011, p. 310)

2.5.6 Discussion

Studies of patients' experiences of acupuncture are relatively scarce, and as far as I am aware, this is the first qualitative systematic review on the topic. Due to the methodology and search strategy used, only studies from the UK, Norway, Sweden, Australia, and the US were included in this review, and these are countries where acupuncture is not generally part of public health systems. As such, patients, perhaps inevitably, compared their experiences with those of conventional healthcare and emphasised the differences. Data from countries where the demarcation between Chinese medicine and biomedicine is less rigid, or at least where there is greater cultural familiarity and acceptance of acupuncture (in China, Japan or Korea for example) may yield different results.

Since most of the participants included were actively attending acupuncture clinics, they were more likely to have derived benefit from treatment and have unrepresentatively positive opinions. Additionally some of the studies that included data from clinical trials (Alraek & Baerheim, 2001; Alraek & Malterud, 2009; Billhult & Stener-Victorin, 2012; Rugg et al., 2011) may not be representative of “natural” setting experiences, however the broad range of studies helps address this.

Another limitation of this review is that while the QARI quality appraisal tool was used to tackle the issue of rigour, quotations presented in original articles may not convey participants’ voices completely accurately, having been taken out of context, or reflecting researcher bias. Nevertheless, this review contributes to understanding the lived experience of acupuncture, people’s motivations for using the therapy and some of its benefits from patients’ perspectives.

2.5.7 Limitations of the review methodology

This review used a structured approach to review the literature. However, there were some inherent limitations to this approach. All types of studies are subject to bias, with systematic reviews being subject to the same biases seen in the original studies they include, as well as biases specifically related to the systematic review process. Reporting biases are a particular problem related to systematic reviews and include publication bias, time-lag bias, multiple publication bias, language bias, and outcome reporting bias (Jüni, Altman, & Egger, 2001). A brief summary of the different types of reporting bias is shown in Table 8.

Other biases can result if the methodology to be used in a review is not defined a priori (i.e., before the review commences). Detailed knowledge of studies performed in the area of interest may influence the eligibility criteria for inclusion of studies in the review and may therefore result in biased results. For example, studies with more positive results may be preferentially included in a review, thus biasing the results and overestimating treatment effect. Some of these biases are potentially present in this review.

Only data published in peer-reviewed journals was included. No attempt was made to include unpublished material since such material typically has insufficient information upon which to base quality assessment, and it has not been subject to the scrutiny of the peer-review process. In addition, the search was limited to English-language publications, so language bias is a potential problem as well. Outcome reporting bias and inclusion criteria bias are unlikely, as I had limited knowledge of the topic literature and the methodology used in the review, and the scope of the review was defined a priori.

<p><i>Table 8</i> <i>Examples of Reporting Bias</i></p>	
Type of bias	Definition and effect on results of review
Publication bias	The publication or non-publication of research findings. Small, negative trials tend not to be published and this may lead to an overestimate of results of a review if only published studies are included.
Time-lag bias	The rapid or delayed publication of research findings. Studies with positive results tend to be published sooner than studies with negative findings and hence results may be overestimated until the negative trials 'catch up'.
Multiple publication bias	The multiple or singular publication of research findings. Studies with significant results tend to be published multiple times which increases the chance of duplication of the same data and may bias the results of a review.
Citation bias	The citation or non-citation of research. Citing of trials in publications is not objective so retrieving studies using this method alone may result in biased results. Unsupported studies tend to be cited often which may also bias results.
Language bias	The publication of research findings in a particular language. Significant results are more likely to be published in English so a search limited to English-language journals may result in an overestimation of effect.
Outcome reporting bias	The selective reporting of some outcomes but not others. Outcomes with favourable findings may be reported more. For example, adverse events have been found to be reported more often in unpublished studies. This may result in more favourable results for published studies.

(Note. Adapted from Egger, M., & Smith, G. D. (1995). Misleading meta-analysis. *BMJ (Clinical research ed.)*, 310(6982), 752-754)

2.6 Chapter summary

This chapter has introduced how acupuncture is conceptualised as a CAM, provided an overview of safety and efficacy, and the qualitative systematic review has synthesised patients' experiences of acupuncture from the international literature. None of the papers included in the review set out to

specifically explore patients' health beliefs, though these were sometimes alluded to in the data. Patients' reasons for using acupuncture, how the therapy was experienced, and some of its perceived benefits were explored. This review has helped focus the research question and provides a backdrop of international literature with which to compare the current study's New Zealand-specific context.

3. METHODS AND PROCEDURES

3.1 Introduction

‘Scientific understanding has always assumed the possibility of a timeless knowledge... whereas all understanding, including scientific explanation, is historically conditioned, is partial and always comes from a point of view’ (Moran, 1999, p. 251).

Broadly contrasting qualitative and quantitative research paradigms against each other risks oversimplification and belies the complexities in each tradition. Nonetheless, there are differing assumptions that underlie each approach that must be acknowledged to harmonise the aims of the research with the methodology applied.

3.1.1 Quantitative versus qualitative methods

Quantitative research approaches are underpinned by positivism, premised on mechanistic and reductionist metaphysical assumptions that the truth, independent of human opinion can be obtained purely through empirical means (Sale, Lohfeld, & Brazil, 2002). Quantitative methods are thought to be objective, occurring in a value-free framework (Sale et al., 2002, p. 44) where the researcher assumes the role of disinterested scientist (Denzin & Lincoln, 2005).

While it is debatable whether quantitative approaches can always be considered entirely objective, they generally lend themselves well to questions concerned with relationships between variables, such as frequency and magnitude. In quantitative health research, validity is enhanced by a number of methods such as strictly controlled protocols, randomisation, and statistical analyses ensuring that large enough sample sizes are used in order for results to be generalised (Carey, 1993). Quantitative methodologies have limited utility in

providing in-depth information around perceptions, beliefs, behaviour and the meaning attached to experiences.

Qualitative approaches, by contrast are underpinned by interpretivism and constructivism, (Altheide & Johnson, 1994; Kuzel & Like, 1991; Secker, Wimbush, Watson, & Milburn, 1995) assuming numerous truths based on individual perceptions. From an epistemological perspective, it is impossible to assess reality independent of consciousness since there is no external way of evaluating conflicting assertions of truth (Smith, 1983). Therefore the “objective” world of Cartesian dualism is from this perspective merely one of many worlds (Laverty, 2008).

Qualitative research designs, originating in the social sciences, are generally less familiar to biomedical and health researchers, and this lack of familiarity has often attracted the criticism that they are subjective or ‘unscientific’ (Pope & Mays, 2000, p. 1) and implicitly lacking in rigour. Using quantitative criteria for evaluating rigour in qualitative research would indeed find it wanting and the relatively small samples used make generalisations to broader populations difficult or impossible. Qualitative approaches are however, concerned with different questions such as those seeking to provide descriptions and interpretations of human behaviour in order to explain phenomena. Whereas quantitative methodologies maintain rigour through strict study design and implementation processes, qualitative methodologies tend to be more flexible, relying more heavily on the skill and approach of the researcher. Arguably this represents a potential limitation, however there are tools for evaluating the quality of qualitative research with different and more appropriate criteria.

Clearly neither paradigm is perfect; both have strengths and weaknesses more apt to answer different types of questions and each approach can support and complement each other. The type of methodology used is informed by the research question, strategy and the theoretical perspective informing the research (Pope & Mays, 2000) as well as the stakeholders who have an interest in the answer (Foundation for Integrated Medicine, 1996, as cited in Gould, 1999, p. 23).

Healthcare provision is a complex field, and an area of research that has increasingly acknowledged the need to understand the patient perspective of the health encounter. To gain such insights necessitates a qualitative methodology—one that allows for rich descriptions of experiences. The question then, is which of the various qualitative approaches is most suitable? Several different methodologies were considered for this project, including grounded theory, phenomenology and hermeneutic (interpretive) phenomenology. A brief overview will be provided before explaining why hermeneutic phenomenology (Heidegger's approach) was ultimately settled on.

3.1.2 Grounded theory

Grounded theory emerged from the collaboration of sociologists Barney Glaser and Anselm Strauss in the 1960s. In common with other qualitative approaches, grounded theory is underpinned by contrasting beliefs to traditional quantitative logico-deductive approaches (Charmaz, 2004). Nonetheless, Glaser and Straus (1967; 1987) asserted that grounded theory can also be compatible with positivistic assumptions and is a method used in both interpretive and more structured positivist analyses. Like other qualitative methodologies,

grounded theory begins with the observation and description of the phenomena being studied, but distinctively, goes further in seeking to generate or discover a theory—an ‘abstract analytical schema’ from the data (Creswell, 1998, p. 56). Glaser believed that the literature review should be postponed in order to avoid developing hypotheses or preconceptions that might bias the research preventing the grounding of theory in the data.

3.1.3 Phenomenology

In the early twentieth century Edmund Husserl established phenomenology as a philosophical movement. Husserl felt that phenomenology was a way of reaching true meaning by delving ever deeper into reality (Lavery, 2008), examining consciousness and describing things, as they are experienced. Phenomenology thus emphasises a person’s experience as it is lived, rather than distinguishing reality as something separate from the individual’s perception (Valle, King, & Halling, 1989). Perhaps influenced by his early training in mathematics, Husserl proposed that objectivity could be achieved in areas normally considered subjective. This, he thought could be done partly through techniques such as *bracketing*. Bracketing is a process that involves the identification and suspension of one’s own presumptions, influences and biases, along with the ‘outer world’. In doing so, the researcher exercises *eidetic reduction* (from the Greek ‘*εἶδος*’, ‘essence’ or ‘shape’) to gain insight into the phenomena of interest (Klein & Westcott, 1994). Bracketing supposedly allows us to see phenomena as they really are (Osborne, 1994) rather than as we think they are—analogous to a skilled artist painting the shapes and colours seen, rather than say, how a given landscape exists as an impression or memory.

Health researchers have increasingly employed phenomenological approaches over the last 10–15 years, particularly in nursing where its philosophical underpinnings—specifically, emphasis on holistically understanding individuals, their experiences and meanings—are thought to be particularly congruent (Lopez & Willis, 2004). Like nursing, many forms of CAM, including traditional acupuncture, have also emphasised individualised care and the importance of understanding the lived experience and meaning (Wolpe, 1985). Phenomenology has advantages in that it allows ‘fresh, complex, rich description of a phenomenon as it is concretely lived’ (Finlay, 2009, p. 6) focusing on, and valuing, the experience of the whole person (Annells, 1996).

3.1.4 Hermeneutic phenomenology

Phenomenology and hermeneutic phenomenology are often referred to interchangeably, without distinguishing their differing characteristics (Lavery, 2008). Both arose from the same German philosophical tradition and have similarities, particularly the rejection of the Cartesian mind/body duality (Jones, 1975), and the focus on human life as it is experienced and the goal of reclaiming what is missed by empirical scientific exploration (Lavery, 2008). In their reporting format, both are similar in their presentation of participants’ stories, inclusion of the researcher’s personal impressions, and consideration of the topic beyond the context of the research itself (Polkinghorne as cited in Lavery, 2008).

Yet there are subtle but important differences, both philosophically and methodologically. Martin Heidegger trained with Husserl in phenomenology and became proficient in this approach, so much so that he became Husserl’s ‘heir apparent’. Heidegger however perceived limitations with Husserl’s approach,

particularly in his belief that biases could be set aside through bracketing (Polkinghorne cited in Lavery, 2008). From Heidegger's perspective, it is impossible to completely extricate oneself from historical conditioning and pre-understandings (Heidegger, 2008). According to this view, *historicality*—a person's history, culture and background—are inextricably linked to understanding and what is believed to be real (Munhall, 1989); a person and his or her world are interdependent, thus interpretation is essential for understanding. Additionally, some have argued that attempting to take the position of value-free researcher actually prevents understanding important aspects of human experiences (Cotterill & Letherby, 1993).

3.1.5 Chosen methodology

As this study is limited to analysing people's perceptions, experiences and beliefs, grounded theory was discarded and hermeneutic phenomenology using Heidegger's approach was chosen as the research method.

In grappling with the philosophical basis of phenomenology, I came to understand that Husserl's approach suits descriptive goals better than interpretive ones. More importantly perhaps, I could not reconcile the notion of bracketing and came to resonate with the view that, 'The investigator and the object of study are interactively linked so that findings are mutually created within the context of the situation which shapes the inquiry' (Sale et al., 2002, p. 45) Furthermore, I felt it disingenuous to present myself as an entirely objective observer of a phenomenon that I have an opinion on and a stake in. Therefore in considering the differences between these approaches, and my own personal leanings as a researcher, Heidegger's approach seemed the most congruent fit.

3.1.6 Method

Hermeneutic phenomenology is typically carried out using the interview as the primary instrument of data collection. Interviews may be either semi-structured, using a number of open-ended questions, or unstructured, with the aim to discuss fewer topics in greater detail. Given the interpretive nature of the research, I opted to use an unstructured approach to interviews.

3.2 Ethics

3.2.1 Ethical considerations

Ethics are fundamental for rigorous research (Davies & Dodd, 2002) and in planning this project I identified the ethical issues and risks, and the mitigating measures that would need to be implemented.

Health information is an inherently personal and often sensitive topic. The interviewing methodology used in qualitative research is designed to be probing in nature (Richards & Schwartz, 2002) and the ‘conversational intimacy’ developed in this setting can contribute towards potential risks (Corbin & Morse, 2003, p. 338) including the possibility for both emotional discomfort and cultural offence.

Additionally, I anticipated that people belonging to vulnerable populations (women who are pregnant, people with mental health or addiction history or those with chronic health problems, for example) might participate in the research.

Interviews therefore presented the risk of:

- Reliving painful memories.
- Speaking to unresolved traumas.
- Fear of judgment.

- Issues of confidentiality and privacy.
- ‘Opening up’ more than was intended, with subsequent feelings of regret.
- Discussing issues that if revealed might cause stigmatisation, (participants may have been receiving acupuncture for the treatment of drug addiction, for example).
- Other painful emotions such as guilt, anxiety, grief.

3.2.3 Risk mitigation

In order to mitigate the risks identified:

- The voluntariness of the study was emphasised in the informed consent and was reiterated prior to commencing interviews.
- Prior to participation, respondents were made aware of the issues that had the potential to surface during interviews.
- All interviews were conducted in an environment where both the researcher and the interviewee felt comfortable.
- All interviewees were invited to express themselves candidly with the significance of their experiences acknowledged without judgment.
- Participants were assured that they were free to end the interview at any stage.

Other considerations included:

- Inconvenience and time expenditure: In-depth interviews ask participants to contribute their time with no immediate direct benefits, therefore it is essential that any such project, if it is to be of wider benefit, be meticulously planned, have relevance and rigour—aspects I have strived for in the execution of the project.

- Conflict of interest: As the interviewer was a member of the NZRA and practicing acupuncturist, there was the potential for a conflict of interest, for example in wishing to present the profession in a favourable light. Questioning in interviews was made in as open and neutral a tone as possible, avoiding leading or suggestive questions. Interviews were transcribed verbatim and participants invited to view the transcript (though none acted on this offer).
- Participant feeling compromised or coerced: Patients may feel pressured to participate out of a sense of obligation, or to ensure the good will of their providers (Holloway & Wheeler, 1995), therefore patients in the direct care of the interviewer were excluded from the research.
- 'Role conflict': It was anticipated that participants might disclose having used acupuncture therapy for purposes that appeared to be inappropriate or unethical. This could have created a clash between roles of researcher and clinician (Bloor, Fincham, & Sampson, 2010), in which case the advice of supervisors would have been sought. Fortunately, this did not arise as an issue.
- Māori considerations: While this study did not specifically examine Māori health issues and uses a mainstream approach (Hudson, Milne, Reynolds, Russell, & Smith, 2010), it was acknowledged in the planning stages that Māori might make up part of the participant population and that the outcomes of the research may be of relevance to Māori. Therefore, advice around the issues considered specific to Māori was sought.
- The research design and consent process ensured that the results of the study could be disseminated fully (HRCNZ, 2010).

- Every attempt was made to ensure that the information sheet was written with clarity and that the intended use of the research was highlighted.

3.2.2 Ethics approval

Ethics approval was sought from the University of Canterbury's Human Ethics Committee (UC HEC). The application was received by the on 1st May 2013 and after several minor amendments, approval was granted on 29th May 2013 (Appendix B). Recruitment was initially slow so I sought an amendment from the UC HEC to advertise the study more widely, which was subsequently approved (Appendix C).

3.3 Sampling and recruitment

3.3.1 Sampling

Since this study focused on a specific therapy, provided by a relatively small number of practitioners, purposeful sampling was used to select participants based on the following criteria: (1) Adults (18 years and over) (2) receiving acupuncture (within the previous 12 months) (3) from traditional acupuncturists, (4) who were able to clearly articulate themselves in spoken English, (5) who were not current patients of the researcher.

In contrast to most quantitative methodologies, interpretive phenomenology does not usually stipulate a strictly predetermined sample since this is informed by emerging themes and analysis. In this approach, theoretical sampling is used. Based on findings and recommendations from similar studies, I estimated that approximately 10-15 participants would be both a feasible number given the resource and time constraints of the project and provide

sufficient data to achieve saturation. By the ninth participant, themes became repetitious and by the twelfth participant, data saturation was apparent.

3.3.2 Recruitment

Canterbury acupuncturists registered with the NZRA were contacted by e-mailing the local register representative and asked to display posters advertising the study to patients attending their clinics. Respondents contacted me directly via both e-mail and phone. Once I had established their eligibility for the study, I sent the Patient Information Sheet (Appendix F) explaining the project and Informed Consent Form (Appendix H) to look over.

I had originally intended to include only participants who had received treatment from NZRA practitioners but as recruitment was initially slow, I made a modification to my original inclusion criteria to include patients of traditional acupuncturists who did not belong to the organisation. I also sought, and was granted an amendment from the UC HEC to display posters more widely at local recreational facilities.

A number of respondents contacted me through snowball sampling, having heard of the study from friends who had seen it advertised.

A number of respondents did not meet the eligibility criteria, because they had not received acupuncture recently or had received it from health providers other than acupuncturists.

3.4 Participants

12 participants were interviewed and their experiences provided the data for the thematic analysis in chapter four. The interviewees included 10 women and two

men ranging from 26 to 68 years of age (see Table 9). All were native English language speakers.

Table 9 <i>Study Participants</i>				
	Pseudonym	Age	Sex	Ethnicity
1	Merida	38	F	Pakeha/NZ European
2	Rose	41	F	Māori
3	Amanda	38	F	Australian
4	Kate	38	F	Irish
5	Lana	38	F	Pakeha/NZ European
6	Sarah	51	F	Pakeha/NZ European
7	Poppy	31	F	American
8	Ella	30	F	Pakeha/NZ European
9	James	55	M	Chinese New Zealander
10	Holly	68	F	Pakeha/NZ European
11	Tessa	26	F	Pakeha/NZ European
12	Jeremy	46	M	Pakeha/NZ European

3.5 Data collection

Prior to conducting interviews, I ensured that participants had read, understood and signed the informed consent forms. Interviews were conducted in a variety of places of the respondents choosing and included the use of Voice Over Internet Protocol (VOIP) (Skype and Google Chat) video interviews. All interviews were audio recorded using a digital Dictaphone. This was chosen as the preferred method to facilitate a better flow and exchange of information without the interruption caused by extensive note taking.

Before beginning interviews formally, participants were given the opportunity to ask any questions about the project. The objectives and methodology necessitated that interviews be as open-ended as possible in order to facilitate the emergence of new themes. Therefore I prefaced questioning by assuring participants that I was interested in their personal story, and that there were no “right” answers. Nevertheless, as the literature review had informed my understanding, and helped shaped the research question, some directed questions were asked. To maintain flow during interviews with less talkative participants, I used a prompt sheet (see Appendix K). Interviews ranged from 20 minutes to about an hour in duration and were all transcribed as soon as possible after, usually within a week (see Table 10).

Table 10 <i>Data Collection Timeline</i>			
Interview	Date Recorded	Date Transcribed	Date of Initial Coding
1	03/06/2013	12/06/2013	18/06/2013
2	11/06/2013	13/06/2013	17/06/2013
3	19/06/2013	22/06/2013	23/06/2013
4	19/06/2013	24/06/2013	24/06/2013
5	21/06/2013	26/06/2013	26/06/2013
6	28/06/2013	30/06/2013	01/07/2013
7	23/06/2013	08/07/2013	09/07/2013
8	01/07/2013	04/07/2013	05/07/2013
9	07/07/2013	09/07/2013	10/07/2013
10	09/07/2013	10/07/2013	14/07/2013
11	10/07/2013	15/07/2013	16/07/2013
12	16/07/2013	17/07/2013	19/07/2013

3.6 Transcription

I listened to all interview recordings several times and checked transcriptions for mistakes before coding them. Personally identifiable information was removed and pseudonyms assigned to participants, practitioners and any other identifiable party. Transcriptions were initially saved as Word documents and then uploaded to Dedoose for coding.

3.7 Data management

I began the coding once interview transcripts were uploaded to the Dedoose data analysis web application. This process continued throughout the data collection phase of the project. Each transcript was uploaded as a separate document linked to a common project in Dedoose. Meaningful segments of text (sentences or paragraphs) were highlighted and assigned codes according to themes and interpretation.

Codes were modified and added as more data was gathered. I used a process of constant comparison going back and forth between transcripts in order to build a picture of patient perceptions and compare themes. Memos were taken during the coding and analysis. These memos were used as field notes to focus thoughts, questions and clarifications for subsequent interviews. I also maintained a reflective journal throughout the data collection phase where I refined some of my thoughts and impressions.

3.8 Rigour

Reflecting positivist discourse, rigour has traditionally been defined as the 'use of logical systems that are shared and accepted by relevant scientists to ensure

agreement on the predictions and explanations of the theory' (Davidson as cited in Ryan-Nicholls & Will, 2009, p. 70). According to this definition, rigour demands objectivity and detachment in research design, measurability and replicability of results (Davies & Dodd, 2002). Obviously, these aims have a strong bias towards quantitative methods and are not necessarily applicable to qualitative approaches. Moreover, it has been well established that complete objectivity in any research endeavour (quantitative or qualitative) is unattainable (Haraway, 1988; Smith, 1987) and striving for it may in some ways be detrimental to effective qualitative research. Replicability, for example, is an inappropriate objective in qualitative accounts of experiences, which are unique and specific to context. Measurability and standardisation require quantitative methods of data collection and analysis and are similarly unrelated to the goals of qualitative inquiry. Any such attempt to apply such criteria for evaluating rigour in qualitative research would find it wanting (Morse, 2004). Evaluating rigour must be fitting to the type of research methods used.

In response to the unsuitability of quantitative definitions, generic criteria for the assessment of rigour in qualitative research have been developed, such as: *credibility*, *fittingness*, *auditability* and *confirmability* (Sandelowski, 1986), the defining characteristics of which have been summarised in Table 11.

Table 11 <i>Rigour in Qualitative Research</i>	
Criterion	Defining characteristics
Credibility	Reading study findings produces recognition of an experience. Those having the experience may recognise it as their own, those not having the experience may recognise it after having only read about it.
Fittingness	How completely the study participants represent the group of which they are members. How study findings 'fit' both the data and other settings. Readers appreciate findings as relevant to their situation.
Auditability	Systematic process of decision-making. Readers may follow the rationale and reach the same or similar conclusions.
Confirmability	Neutrality of study findings. Achieved by fulfilling all of the above criteria.

(Note. Adapted from De Witt, L., & Ploeg, J. (2006). Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing*, 55(2), 215-229.)

This model is a generic exemplar for all types of qualitative research and inevitably some of its aspects will not perfectly fit the philosophical or methodological nuances in interpretive phenomenology (De Witt & Ploeg, 2006). Nevertheless as a guide it has been used to inform this project.

3.8.1 Credibility

The phenomena in question must be represented authentically and faithfully for credibility to be satisfied (Beck, 1993). By outlining my background and interest in the topic, and by explaining the reasons for the chosen methodology, I have attempted to explicate pre-understandings of the topic, which is an essential step in assuring credibility. Of course it is insufficient to merely state one's presumptions and biases at the outset, never to reflect on them again. Accordingly I made constant efforts during both data collection and

analysis to ensure that it was the participants' experiences that were interpreted and not my own. Using a reflective journal throughout aided in this process.

Some procedures deemed to be helpful in ensuring greater credibility, such as using a panel of judges to review data analysis processes to reduce bias (Beck, 1993), have been necessarily omitted due to constraints inherent to a master's thesis project, however I have used extensive excerpts presented contextually in endeavouring to represent participants' voices faithfully.

3.8.2 Fittingness

Fittingness (closely analogous to transferability) is demonstrated when the findings of the study are likely to be meaningful to others having had similar experiences (Speziale, Streubert, & Carpenter, 2011). Ultimately only the reader can assess this, however the findings of this study demonstrate a resonance with those of similar previous studies, indicating a degree of fittingness.

3.8.3 Auditability

Research is auditable when another investigator can easily follow the processes applied in the study. Repeating the study accordingly would probably lead to similar conclusions given a parallel perspective, situation and population. In order to achieve auditability in this study I have described the purpose of the research, delineated both my interest on the topic of investigation, as well as the theoretical/philosophical stance underpinning the study and explained how the participants were recruited. I have also described the processes of data collection, coding and analysis.

3.8.4 Confirmability

Confirmability is achieved when credibility, fittingness and auditability have all been addressed (Koch & Harrington, 1998).

3.9 Chapter summary

This chapter has provided an outline of the processes of sampling, recruitment, data collection and management. The steps taken to ensure rigorous research, including ethical considerations have been delineated, and the participants introduced.

4. ANALYSIS AND INTERPRETATION OF THE DATA

4.1 Introduction

This chapter presents the thematic analysis of participants' experiences, their perceptions and health beliefs. *A priori* codes had not been developed before undertaking the analysis. Five overarching themes were identified:

- Usage
- Components of therapy
- Effects of treatment
- Health system and integration
- Health beliefs

4.2 Usage

This theme encompasses how and why participants employed acupuncture and the factors that impacted access. Usage was comprised of three subthemes: conditions treated, reasons for use, and access. The former two were coded individually since participants generally identified them as separate issues. So while 'headaches', or 'hypertension' for example, were coded as 'condition treated' they were not interpreted as reasons for use, since there are a number of interventions that might be used to treat either condition. 'Dissatisfaction with biomedicine' by contrast, constituted a reason for use, though as one would expect these two subthemes emerged with a considerable degree of overlap.

4.2.1 Conditions treated

Acupuncture was used to treat a fairly diverse range of conditions with painful, particularly musculoskeletal problems, and gynaecological disorders the most common. Painful and musculoskeletal conditions included headaches,

idiopathic acute and chronic joint pain, other neurological pain, musculoskeletal injuries (sprains, strains, ruptures), and prolapsed vertebral discs. Gynaecological conditions included dysmenorrhoea, pre-menstrual syndrome (PMS), oligomenorrhoea, infertility and 'perinatal support'. Other conditions included common cold, depression, chronic fatigue syndrome (CFS), diabetes, macular degeneration, relief of drug side effects and general well being or 'prevention'.

For musculoskeletal conditions, acupuncture was mostly used in an analgesic capacity—as a second line of intervention—where drugs had failed to provide relief:

I had a prolapsed disc in my lower back and I was doing a lot of physio[therapy] and taking fairly strong pain killers which both of those things didn't really seem to [make] much difference I was in... an extreme amount of pain all the time... I thought I'd give acupuncture a try. – Ella

I'd actually ripped through some muscles in the back of my left shoulder... taking pain killers wasn't relieving the pain, wasn't helping me sleep, wasn't helping me get on with my life. – James

Around half of the participants had used acupuncture either alone or in combination with herbal medicine for gynaecological issues such as oligomenorrhoea or PMS:

I had missed my period for nine months but I wasn't pregnant. So I was using... acupuncture... [my practitioner also] gave me herb[al medicine]... I was regular again, everything was fine... I was really surprised... at the effectiveness of... such a seemingly simple treatment. – Poppy

When I get my period and I get real big [emotional] highs and lows... throughout the month. And I've found it to be very, very difficult for going forward in my life and planning things. Because every month I get depressed for about four days. And while I'm in that time I can't see out of it. Like I think that this is what I'm like the whole time. – Ella

Others had sought treatment to assist with conception and pregnancy:

The main longest course [of acupuncture] I've had is for fertility. – Lana

I started [acupuncture] because I'd had a miscarriage and [wanted to get in] as good a state as I possibly could, as healthy as possible... and then from there it was more about getting healthy to get pregnant. – Kate

4.2.2 Reasons for use

The factors that prompted the first use of acupuncture most often related to dissatisfaction with ineffectual conventional treatment; the perception that the 'root' of their problems had not been addressed, and sometimes because of negative experiences with medical professionals. Participants who had used acupuncture previously tended to consider its use more readily, for a wider range of complaints, and were motivated by an increasingly diverse range of reasons.

For painful conditions, several participants described that they had unsatisfactory results taking analgesics or non-steroidal anti-inflammatory drugs (NSAIDs). Without any forthcoming medical alternatives, acupuncture was thought to be 'worth a try'. Ineffective symptomatic management was not the only reason for dissatisfaction with pharmacotherapy; some also identified a

more general scepticism or mistrust towards what they perceived as the injudicious use of pharmaceuticals:

I think modern medicine has just become so smart that it's... got so many sort of purpose-built drugs... I've always been a wee bit sceptical about taking drugs and I've never been one to sort of rush off and want antibiotics. – Sarah

[It] seemed like a lot of them would just give you antibiotics for everything and anything. That was just something I didn't want to do... that whole drug approach to things just doesn't fit or sit well. – Merida

Diagnosis from the doctor, [he says] 'you've got that [problem] so take that tablet', whereas I feel [the acupuncturist is] treating me for the person that I've always been. And I'm working my whole system to get me in tune. – Kate

Concerns were also voiced about the possible adverse effects of taking medication, particularly on a long-term basis. As one participant rationalised, 'I'm already taking enough nasty stuff every three weeks [chemotherapy drugs] now, so I didn't really want to keep adding other stuff into my body' (Sarah). More significantly though, this scepticism foreshadowed the opinion that the root of the problem had not been addressed:

The painkillers were—Tramadol [an opioid analgesic used to treat moderate to moderately severe pain] is what she gave me... yeah they're just very strong and I was taking about six of them a day and I just really

didn't want to be taking such strong drugs so regularly for a long period of time... just to be covering the pain and not actually be fixing it. – Tessa

Significantly, the word 'mask' was used repeatedly in reference to managing symptoms with drugs, implying that pharmacotherapeutic approaches were biased towards suppression of symptoms, rather than 'cure'.

Structural (i.e. health system) factors also appeared to contribute towards participants' sense that biomedical treatments were superficially or symptomatic biased. Several interviewees, for example, felt that there simply was not adequate time for their GPs to reach satisfactory treatment plans during appointments, 'In the past if I've gone to the GP about a certain thing... everybody's a lot busier nowadays and I think GPs are on a pretty tight schedule for appointments as well... they don't have time to actually look at you as a whole person' (Sarah).

One final but less common feature that had contributed towards dissatisfaction for some interviewees was a sense of disempowerment experienced during consultations with their doctors:

[The exchange with my doctor] made me a bit grumpy because... I thought I was right, I walked away from [him] feeling really... un-empowered... he was like 'oh there's nothing really you can do about it'... [the next doctor I went to said] 'oh yes, you have got intersection syndrome'... I'm like, 'oh ok, what can I do about that?' And he's like 'oh, just be on light duties'... [they] didn't fix anything... So I felt like the doctors were just were just... disempowering. – Ella

Ella went on to explain that she was not upset by her doctors' inability to help so much as what she perceived as their lack of empathy and unwillingness to suggest alternatives, or to refer patients to CAM practitioners. Having had similar experiences on several occasions with different doctors, she went on to form a rather negative opinion of the biomedical model in general. Lana also had a similarly disempowering experience:

I got pretty frustrated with my doctor who wasn't very supportive, who basically thought I was being a bit of a basket case and was just saying 'oh it'll just take a few years, just go with it, don't get stressed out', but I wanted to be a bit more proactive.

Whereas the factors described above constituted the major reasons for using acupuncture in the first instance, many participants considered its use more readily and for different reasons after experiencing treatment.

Most regular acupuncture users had developed an understanding of and affinity for aspects of Chinese medicine theory and philosophy. For these people the philosophical basis of traditional acupuncture seemed more congruent with their personal health beliefs. Many also came to place value on the close relationship that they had developed with their practitioners who subsequently came to play an important role in their healthcare network and for some was seen as their principal healthcare provider, 'I will go to my acupuncturist first. And I will choose to take Chinese herbs and have acupuncture rather than go to the doctor' (Rose).

These people had initially sought acupuncture for a specific problem, and later came to the view that acupuncture had a much wider range of applications:

'[Acupuncture could] probably [be used for] any problems that you had... your joints or your back or... your insides... I would suspect that it can be used for most things... it can be all sorts of different things... the needles help with... the blood flow' (Sarah).

4.2.3 Access

A number of different factors impacted access to acupuncture including information sources, referrals, practitioner availability and funding sources. Information sources included family and friends, GPs, and other CAM practitioners:

My Dad suggested acupuncture... he was talking to his acupuncturist about [my problem] and he said 'that's easily fixed with acupuncture'. – Ella

I heard about [the acupuncturist] through, I think it was through a friend of mine... Mum had been to acupuncture previously and she swore by it. – Amanda

Friends recommended that I go and see [her]. – Rose

Funding source, availability and convenience were identified as influential considerations in some interviews. By and large, participants had attended small private clinics, usually with sole practitioners. This practice model, coupled with long appointment slots creates limited flexibility and availability and was identified as a barrier to access. Consequently, although some participants indicated a preference to see an acupuncturist as their first choice of practitioner, at least for certain conditions, they ultimately sought treatment elsewhere:

If I had say, a sinus infection, I'd usually go to my GP... [Because it is] more of a convenience thing. Like with [my acupuncturist], I usually need to book in a week or two in advance, whereas with my doctor, if I'm unwell, I can go and see [them] on the day. – Merida

The nature of the presenting complaint also influenced the extent to which convenience was a consideration. Those who had sought treatment for simple musculoskeletal complaints were less concerned about who they saw:

I picked this one myself, because it's close to where I work and they're open on Sundays... it is more of a convenience thing... there's a few around that area where I work but [the clinic I chose was] easy to get to from where I work [so] I just picked that one. – James

Conversely, for conditions viewed as more serious or personal in nature, choice of practitioner was more important and convenience a less significant consideration.

Three different funding streams were discussed in relation to accessibility. Most participants had either funded treatment by OPP or through third party private insurance, or ACC. The cost of OPP treatment was thought to be quite high and sometimes described as prohibitive:

[One reason for delaying treatment was] not having extra money and things like that... so I've finally settled for a good year and I've got a good income so I can afford to see someone about it... I do have trust in her. Because I fork out often over \$100 a week to her...[and] I'm not on a big wage. – Ella

I'm not in the financial position to do it at the moment, but if I was, I'd be having regular acupuncture, as a means to keeping myself healthy. –
Amanda

Holly, who had several drug allergies, used acupuncture in lieu of pharmacotherapy felt happy to pay OPP but was concerned about its future affordability, 'I mean I know that the [drug is] funded but it doesn't work for me and I choose to do something that works better and if I have to pay for it, as long as I can afford to I will pay for it. When I can't, well then I'll have to panic'. Similarly, Lana felt comfortable paying privately to use acupuncture for 'fertility support', where she felt she was exercising personal choice, but believed that if acupuncture was known to be an effective treatment option for diagnosed medical conditions, it should be funded as drugs are in New Zealand:

We were very happy to use it as an alternative and paying for it for fertility because we saw it as a really good option... I don't mind paying for it but I do think that you had something that was diagnosed... like chronic headaches... then it would be good if it was funded.

Several participants had acupuncture funded by ACC, which they regarded as 'nice', but not an essential deciding factor in accessing the therapy. Tessa, for example, who had sought acupuncture to treat significant pain and disability subsequent to a vertebral disc herniation said:

I think I would have still gone... my mind frame at the time was I just need to try anything to try and get this fixed... [it] helped [that ACC covered treatment but] if it was literally me just [paying OPP for] physio and acupuncture, I think I still would have paid to go.

Rose, who had been having acupuncture regularly for years, paying with OPP, echoed this sentiment, 'I've had several treatments [that] ACC [paid] for... problems with my elbow... [and when I have to pay OPP I have it less frequently] just 'cause it's not affordable.'

Even when ACC funding was available, it was not always accessed due to the perception that the referral pathways or claim approval processes were obstructively time-consuming or bureaucratic: 'I wanted the benefits real quick... [ACC would have covered the treatment but] I paid for it myself' (James).

4.3 Components of therapy

This chapter sets out to investigate participants' experiences of the *therapeutic encounter* in acupuncture. It examines how the various components of therapy were perceived and the significance attached to each of them. Broadly, participants' accounts were constructed of the following elements: intake and diagnostic processes; specific techniques such as needling¹, moxibustion², the prescription of herbal medicine and other self-care strategies; and the attributes of the practitioners themselves.

Participants usually described having been through a thorough intake process, which included extensive questioning about the presenting complaint

¹ The insertion of very fine needles at specific body sites. Needles are usually left in situ for up to half an hour and may be stimulated either manually by twisting or lifting and thrusting the needle, by heat, or by the application of an electrical pulse.

² Moxibustion refers to the application of heat to acupuncture points. This is achieved either by burning an herb, artemisia directly on the body, indirectly by holding the moxa in close proximity to skin, or by its application to an acupuncture needle *in situ*.

and past history; the use of palpation and traditional diagnostic methods, particularly pulse³ and tongue⁴ diagnosis:

She did very, very thorough assessments prior to starting and... discussed everything medically, which was really good... before she started doing acupuncture and just kind of gave me a really good understanding of what she was about to do. – Lana

Each session was about an hour. The acupuncturist would ask just how I was; how I'd been over the last week... he did quite a bit of pulse testing... – Merida

We spend an hour talking about me and anything that I could think of that was wrong with me. And you know, she wrote all these things down. And so she took on board, you know, a lot of what was going on, rather than just the specific complaint that I was asking [about]. So yeah, it is more than just needles. – Ella

Traditional diagnostic procedures like pulse and tongue diagnosis were unfamiliar to most participants and met with intrigue, and occasionally by amazement at their accuracy:

I [don't know] how somebody feels your pulse and then says to you, you have a problem with this or a problem with that. And they're absolutely

³ Rather than simply counting the heart rate, traditional Chinese medicine practitioners palpate the 'qualities' of the radial pulse in different positions. The quality of the pulse at each position is thought to reflect the state of various organ systems. A 'wiry' pulse for example, might indicate disharmony of the Liver system, when corroborated with other signs and symptoms.

⁴ Tongue diagnosis uses the colour, shape, moisture, movement, and coating of the tongue to infer the patient's state of health (Hicks, 2008) based on traditional Chinese theories of physiology, and like pulse diagnosis, is taken within a broader context of the patients' other signs and symptoms.

spot-on, from feeling your pulse, from walking around your body, you know. That, that to me, that's incredible. – Amanda

Some interviewees regarded the intake process as important not only for the practitioner in the formation diagnoses and treatment strategies, but as an integral component of the therapeutic effect itself:

We sat and had a huge chat, and talked about a lot of things that were going on in my life and about my work and about... things that were coming up. And so there was a lot of that sort of conversation and she just seemed to understand where I was in life. She just seemed to get me. And she seemed to get me from a sort of, you know, from a mental perspective... definitely from a spiritual perspective as well. And I think that really sort of helped. – Amanda

Jeremy who worked as a physiotherapist, also acknowledged the importance of the diagnostic process, the patient-practitioner exchange and many intangible aspects of treatment. He also reflected on the similarities between acupuncture and physiotherapy in this respect:

There's no way we [as health practitioners] can break components of our treatment down. We can't take communication out of our treatment, we can't take... just listening and... hands on you know, touching... out of the picture, so it has to be a combined approach or a combined model.' – Jeremy

It seems too, that the in-depth intake process played an important part in the perception that treatment was holistic and being individually 'tailored': 'You can tell that its individualised to you ... it's not like a generic thing' (Lana).

Explanation of treatment strategies and techniques was also quite detailed, at least in initial consultations:

[The second acupuncturist I went to was] really good at... explaining why I might not be feeling well, of what's out of balance in my body and what might bring me back in balance whether that might be needling a point or some sort of herbs and... what I need to eat, diet, that sort of thing. – Merida

This kind of thoroughness was not universal however. One participant in particular described a very cursory consultation and conspicuous lack of communication around how treatment would proceed:

He asked me initially... where the pain was and... what I've been diagnosed with... sort of felt around the area and I guess made up his own mind. There wasn't a lot of conversation... I guess maybe [I would have preferred more explanation such as] a quick run down of... what he's looking for and what he is doing by shoving the needles in me. – Tessa

This interviewee did speculate that her practitioner, a Chinese gentleman, may have had limited English-language fluency and different cultural expectations or mores, which impacted the therapeutic exchange. Irrespective of the reasons, one consequence was that she failed to report extensive bruising caused by her treatment despite being quite concerned, and did not revisit the practitioner: 'I guess also because there wasn't a lot of communication... between us during that

time so it didn't seem like a very approachable kind of situation because he wasn't very chatty about what he was up to.'

Though she seemed to ascribe recovery from her back injury, at least partly, to the acupuncture, Tessa described her experiences in much less positive terms than other interviewees and her lack of enthusiasm appeared to be a product of both inadequate communication during the consultation, and an adverse reaction (albeit a relatively mild and self-limiting one).

Needling, moxibustion and other techniques usually made up a relatively minor part of participants' stories. Discussion mostly related to prior expectations, for example of being apprehensive about needles, 'Initially, like everyone I was a little bit reserved about it because I'm not a fan of needles but after I had the first treatment and I experienced the benefits of it that fear of needles kind of went away' (Rose). Others recalled the physical sensations experienced such as the feeling relaxed subsequent to needling, or the pain occasionally felt upon needle insertion:

She'll put the needles in and mostly there's no feeling, occasionally you'll get a wee sharp one and occasionally you'll feel if it's put in here [indicating shin area] you'll feel it jumping across or down a toe or something like that... but generally speaking no, no problem with it at all. – Holly

I almost feel like I drift off. But she assures me I normally don't but it feels like the hour just goes like that. Umm yeah it's lovely. Really nice... in years gone by I've done quite a lot of meditation and it almost reminds me of meditation... and you just feel like you're not in your body actually... It's a really nice feeling so it's certainly not scary or painful. – Sarah

It just felt like an electric shock like coming through my fingers and like my toes and stuff... it kind of hurt. – Poppy

Occasionally more remarkable reactions were experienced during the needling process:

She put needles in me and left the room, and I was lying there, I wasn't frightened, but I was just kind of going 'what the hell is going on'. I felt like my pelvis was being ripped apart. Not ... in a scary way, but I had this really strong sensation that my pelvis was splitting in two. It was so weird... I had huge surges of energy and it was the strangest experience I've ever had. – Amanda

Moxibustion, and the application of intra-dermal needles and ear-seeds elicited cursory mention, while about half of the participants' said their acupuncturists had prescribed herbal medicine:

I went back a few times, took lots of herbs. – Amanda

[I went to the] Chinese doctor who did acupuncture and I took herbs for a couple of weeks, which made me feel better also. – Poppy

I've also been taking... a course of this magnolia flower remedy. – Sarah

Whilst I was having the acupuncture, she'd go and mix up all the herbs... for her acupuncture might be slightly more secondary to the herbs I think – Lana

Self-care recommendations were almost universal and consisted of suggestions to take sufficient rest, recreation, appropriate diet, and sometimes, the practice of specific exercises (such as stretches or breathing exercises):

She talks a lot about... finding the time to nurture and rest and replenish and that really makes sense in terms of trying to have a baby... She just is really good at explaining things so I really understand what's going on and gives me some options [for self-care]. – Merida

I learned that...[the] types of food to be attracted to, [that are beneficial are] the types of food I'm attracted to anyway... she made me read a book, which was really interesting. She made me read *The Infertility Cure*. – Kate

She gave me... an exercise to do... Standing up and almost taking like a star shape, opening up the front of my body, She asked me to do that every day... she said to me 'you need to get in the ocean, seawater will be really good for you'. And... she gave me a chicken soup recipe and said 'I want you to eat that, it's really good for your qi'. – Amanda

Much of this advice was not unique or unfamiliar and very often was regarded as 'standard' or consistent with recommendations from other practitioners:

[The advice is] fairly consistent. My GP treats homoeopathically, [using a] holistic approach so there are some similarities. – Merida

[My acupuncturist recommends] the standard stuff—eat better, sleep more, don't party so much. Be good to yourself emotionally... exercise... it's all the same stuff, it is very simple at the end of the day isn't it? That everyone's always advising on. – Rose

Some participants spoke of their practitioners' professional training, considering this to influence the therapeutic process. Emphasis was placed on the technical skill and diagnostic competence of the practitioner, and most interviewees felt that treatment was somehow different when delivered by an acupuncturist, compared to other providers (GPs or chiropractors for instance) using acupuncture adjunctively:

I don't go around saying I'm a chiropractor after a weekend course... I'm like that with anyone. You know, I wouldn't go to a backyard mechanic, I would go to an actual mechanic that's got all the [qualifications], got all the registrations... acupuncture's such a powerful form of medicine I wouldn't just let anyone stick needles in me. – Rose

If you don't have good diagnostic skills then you might as well be throwing a dart...[without good diagnostic skills] 20 to maybe 50% of the patients will be better anyway... what makes you a good therapist, in that top 20%, is whether you actually can diagnose, whether you can pick the difficult one – Jeremy

For some participants, practitioners' personal attributes were also integral to the therapeutic encounter and contributed to the development of close relationships, mostly for those who were receiving long-term treatment:

She's a very lovely lady, she's very calm, caring, and you know you it actually feels like she cares. – Ella

I feel she knows what she's doing. She's ... very calm... very gentle and very sincere. And she doesn't force things on you at all. – Sarah

Suggestions were also ventured as to how these personal attributes influenced the therapeutic outcome, for example facilitating the cultivation of trust allowing the patient to feel comfortable enough to be frank and open: '[If] the healer trusts themselves... then they're probably gonna have greater success... if your bond is stronger, closer, and the trust is there, I think that [the patient is] more available to open up and really allow something to... happen' (Poppy).

This was thought to be of universal importance to health providers irrespective of modality and Poppy went on to posit:

If your nurse is kind of happy and upbeat... that does affect the patient's well-being, for sure... in a hospital... if the nurse is you know, having an off day... that's gonna effect the health of her or his patients. ... the healer's health, well-being, and ability to create a trusting relationship, is gonna impact the effectiveness of the treatment for sure.

4.4 Effects of treatment

This theme refers to the outcomes that participants experienced from having acupuncture. Having sought treatment for a wide range of complaints, participants attributed an equally varied array of effects to treatment. This theme is comprised of two main sub-themes: symptomatic changes and broader impacts.

4.4.1 Symptomatic changes

Participants spoke of specific symptomatic relief immediately after treatment as well as longer-term changes with sustained treatment. Changes included pain-relief; reduction in swelling and inflammation; changes to circulation, respiratory, gastrointestinal, and gynaecological systems; and mental/emotional changes.

Some participants described the effects of acupuncture to be quite instantaneous. Sarah, for example, who was using acupuncture to relieve sinusitis secondary to the anticancer drugs she was taking, experienced quite immediate changes:

I notice such a difference when she puts the needles in my face in particular, it just feels like I'm lifting, it's just incredible, you know' ... I was quite amazed actually about how quickly I felt [better]... even [before I] got off the table I could notice a big difference in how I could breathe.

Similarly James, experienced rapid pain relief and increased mobility immediately after treatment:

Straight afterwards I felt good. I wasn't up and dancing but the pain felt better, when I got off the table, I felt better. Getting dressed was a lot easier than when I got dressed to get on the table if you know what I mean.

For others, changes occurred incrementally over a series of sessions. Poppy, for example, who had quite intense physical sensations during treatment, provided this account:

I...was kind of surprised [at the] initial reaction that I had at the first treatment...it was just, I've never felt so bad in my life. ... I mean it was like a gut wrenching feeling. It was so bad ... then it felt like a release, like ... I

felt like someone was ... squeezing my heart. ... [And after] it felt so much better. And after the third [treatment], then I felt actually, you know, much more balanced... it was an interesting kind of journey, just within one week of like those three treatments. Like, how different I could feel, on an emotional...level. – Poppy

Those who presented with more chronic health problems, correspondingly tended to experience much more gradual and less dramatic changes:

The acupuncturist I saw at the time did say it would take a while so I knew that from the start. So I probably went for about a year once a week at least for about a year but I think it would've been one of the main things that saw me come out of that chronic fatigue state...[later on and when seeing another practitioner for 'fertility support'] my periods and menstruation changed over that period of time so there was something... changing in a way that would support getting pregnant and then I got pregnant—that was a good indicator that it was working! – Merida

Symptomatic changes did not always appear to be directly related to the presenting complaint and often changes were multifaceted. Increased energy levels, better sleep, and a greater sense of relaxation and well-being were all commonly reported:

My circulation has changed. My hands are not so cold and my feet are not so cold and I can see my veins a lot more clearly than I ever have, all of these things have changed... before acupuncture I was getting up at 9.30 or 10 and I'd wake up and I'm tired... just wanna go back to sleep, and now I'm waking up at 7.30 and I'm ready to go. And I'm like 'wow this is great.

[Treatment has] given me loads of energy'... I've always had really sore shoulders... that's almost gone now as well. – Ella

Well the benefits aren't ever just physical, it's kind of more than just the physical level when I feel better. It's an emotional level, energetic level... Everything feels better when I see her. – Merida

Partly because of this range of effects, and partly because many of these changes were subjective, a number of participants were cognizant that they might not lend themselves to being measured:

It's hard to know specifically [but] I definitely thought I was a lot healthier, and even if it was a better state of mind or whatever it definitely helped. – Lana

If you've got a sore knee and it gets better, easy... Whereas... treating the whole body system is a little hard to you know, 'prove', I would imagine – Kate

I don't think you can measure it that way because ... you can't measure it with a blood test or anything, but the end results are beneficial. – Holly

At the same time, quantifying outcomes did not necessarily appear to be important to participants:

I don't really care if there is scientific data to back it up, but I think when you're working with energy, how do you measure that? – Amanda

I definitely felt something and I felt different after... [and that is] the most important thing... maybe it doesn't quite matter exactly the science of what's going on, as long as there's an after effect. – Poppy

I'm very pleased with the results and if the medical system doesn't acknowledge it, well that's fine. I don't mind. – Holly

Outcomes were not always positive and a number of participants experienced adverse reactions from treatment including increased pain and bruising from needles. Some spoke about having derived no benefit from acupuncture, though interestingly, they tended to ascribe such failures to the acupuncturist, rather than the modality, and subsequently sought different practitioners.

4.4.2 Broader effects

Beyond specific changes in symptoms, some respondents identified wider effects. These ranged from relatively minor changes such as feeling reassured or supported by their practitioner, developing new strategies for self-care, through to more profound shifts including changes in self-understanding or worldview.

[Having acupuncture has] added to that understanding over the years, [giving me a] more ... holistic view that ... illness is a bit more layered... a bit more complicated. – Merida

[My acupuncturist] definitely gave me tools... to make positive change in my life and ... that gave me a genuine interest in wanting to know more and wanting to learn more. – Rose

Participants who had been receiving acupuncture over a longer period of time, often described developing a new understanding of health from a Chinese medicine perspective during the course of treatment:

'I know now that I'm Kidney Yang deficient...it's been an absolute blessing understanding that because I've been cold all my life, and I thought it was just me. I'm always cold, [and I have an] aversion to cold. My hands are cold, I like the heating, I have terrible power bills, you know... [understanding my TCM diagnosis] it's like oh sweet, that's just the way I am...[which] made me feel validated in the way I am. – Kate

I didn't know that [sinus problems] came from your Spleen... I would of thought it was all just coming from my head and my nose and my nasal passages sort of thing... I know the understanding of how the sinus thing can affect your whole body, [so] I'm actually not so worried about some of the symptoms I have... it's just confirmed to me [my acupuncturist] telling me about certain ways the body works. – Sarah

While pleased with some of the specific symptomatic changes brought about through acupuncture, the tone of responses suggested that the broader changes experienced by some participants held much deeper significance.

4.5 Health system and integration

This theme is defined by the interactions of patients, practitioners and modalities within the health system. While the focus of the research was specifically on acupuncture, it became evident that many participants contextualised their experiences of acupuncture as an unconventional therapy,

often making references and comparisons to other CAM modalities they had used, and describing the (lack of) communication between different practitioners and modalities. Three sub-themes are presented here: concomitant modality utilisation, inter-practitioner communication and referral, and perceived practitioner attitudes.

4.5.1 Concomitant modality utilisation

Biomedicine and various forms of CAM were frequently used complementarily (i.e. to help with the same issue) or simultaneously (i.e. to treat unrelated issues). In addition to acupuncture, participants had used vitamins, other dietary supplements, Ayurvedic medicine, homeopathy, naturopathy, and various forms of manual therapy such as osteopathy, chiropractic and massage:

[I used] reflexology, deep tissue massage... and just incorporated them, they just became part of our natural life. – Holly

[I go to] the chiro[practor], I go to pilates, reflexology, and I'd probably have the odd massage as well. – Amanda

The extent to which participants discussed their use of other modalities with practitioners varied. Most respondents (and their practitioners) seemed to view concomitant use of biologically-based CAM therapies as most important to disclose with doctors, presumably due to awareness of possible drug-herb interactions: '[The acupuncturist] wouldn't let me start those herbs until I'd shown [the oncologist] the list of ingredients' (Sarah).

When explicitly asked, participants also disclosed using acupuncture and other types of CAM, 'I have always stated on all my [patient intake forms] that I have acupuncture and [take] herbs' (Lana).

Mixing of modalities made it difficult for some participants to discern where they had derived therapeutic benefit:

It's hard with acupuncture 'cause I think it's all to do with the herbs I'm taking to regulate my cycle. And the vitamins that I'm on, fish oils, you know the diet... lack of sugar... processed foods. I think that's all a combination, so I can't exactly say now acupuncture has done this for me. –

Kate

However, this uncertainty did not appear to motivate attempts to isolate what was most helpful.

4.5.2 Inter-practitioner communication and referral

Participants spoke of how they perceived the communication and relationships between their acupuncturists, other CAM providers and biomedical practitioners. Two categories of inter-practitioner communication emerged: i. intra-paradigmatic (i.e. CAM to CAM and biomedical to biomedical) and ii. inter-paradigmatic (i.e. between CAM and biomedical practitioners).

i. Intra-paradigmatic communication and referral

Despite the heterogeneity among various CAM modalities, participants felt that their different practitioners would be able to communicate and inter-refer comfortably with each other. However, formal correspondence was sparse, and referrals were ad hoc and based on casual networking. While increased communication was thought to be desirable—'it would be great if my Chiropractor would or could communicate more with my yoga teacher, who could communicate with you know my Chinese medicine practitioner' (Amanda), the practical difficulties were acknowledged and only one participant had

experienced a formal written referral, 'My naturopath sent [the acupuncturist] a referral letter' (Kate).

Intra-biomedical referral processes and communication were viewed to be structured, formalised and stratified in comparison to CAM. A number of participants spoke of their GPs referring to specialists or allied health providers such as physiotherapists. This type of referral was thought to be commonplace and unremarkable.

ii. Inter-paradigmatic communication and referral

Generally communication between acupuncturists and biomedical practitioners was perceived as minimal, even when participants were using both modalities simultaneously. Accordingly, when discussing this topic, the observation was made that communication predominantly tended to be intra-paradigmatic, i.e. 'medical-to-medical, and [CAM-to-CAM]' (Kate). Indeed there were mixed feelings as to how feasible or meaningful inter-practitioner exchange would actually be because practitioners speak different 'languages'. For instance, when asked whether she felt a higher degree of communication between her acupuncturist and physiotherapist would have been helpful, Tessa responded by saying:

Yes and no... I feel that what the acupuncturist was doing for me and what my physio was doing were very different [and] that communication between the two practitioners would've been good in a way, [but] I wouldn't be confident that they would be able to communicate well enough for it to even matter.

In this excerpt the inference is that inter-practitioner/inter-paradigmatic communication might be a difficult issue to overcome, although Tessa did describe her acupuncture practitioner as being quite uncommunicative in general. Nonetheless, she was not the only person to raise this question: 'I feel like their body map is quite different. Or their gospel is quite different... what they believe in is very different, so they will speak a different language' (Ella).

Despite these perceived barriers most participants thought that greater interdisciplinary communication would be laudable, particularly in the co-management of serious illnesses such as cancer:

I'm absolutely happy with the way it is at the moment but let's say if I had cancer and I was going through the public system and I had oncologists and all the other people, and I want them to be talking to each other and I want the acupuncturist to be supporting what I was doing... communication would be really important. – Merida

Interestingly, the two participants who expressed the aspiration for increased inter-paradigmatic communication most enthusiastically both worked as biomedical professionals:

Without a doubt, of course you can [have better communication]...you have to. – Kate

Allied health [practitioners], hand therapists, physios, chiropractors, podiatrists, acupuncturists, nutritionists, herbalists... we should feel comfortable to refer... I certainly refer more to acupuncture than any other health provider... I send people to x-ray if they want an x-ray, to a surgeon

if I think it's something that needs surgery... just the same as acupuncturists should feel comfortable sending people to physio or podiatry or to their GP or pharmacist if it suits. – Jeremy

Jeremy's comment is perhaps also significant in reference to acupuncturists, herbalist and chiropractors as 'allied health practitioners', thus blurring the distinction between conventional and CAM healthcare. In fact, he conceded that he did not 'really understand the difference [between CAM and conventional medicine]. I don't know that there should be a difference... it's almost like [it's] just a power struggle.' He also went on to explain his perception that the division and marginalisation of CAM providers from health systems, and subsequent lack of communication, was partly due to the maintenance of professional control by particular groups: 'Our health system is as much political as functional, you know about who's in power and who... controls the purse strings.'

Given the limited communication between CAM and biomedical practitioners, it is unsurprising that recommendations and referrals were also minimal. 'Referral' was a loosely used term and most often constituted a vague suggestion to try a different modality. Merida, for example, explained that her GP recommended that she should 'think about trying some other things...[naturopathy, massage or acupuncture]' since she had exhausted biomedical treatment options. Occasionally participants described biomedical professionals having recommended CAM more proactively, and two had direct GP referrals to acupuncturists. Biomedical practitioners had also made recommendations for biologically based therapies and products such as vitamins and supplements:

I did start taking fish oil because apparently that's meant to be very good for your joints but it was actually recommended to me by a pharmacist. – Tessa

[My doctor practices] integrated health, and so she set up quite a regime[n] of herbal products that I had made up at the herbal dispensary. – Sarah

It was more common for acupuncturists and other CAM providers to refer to biomedical practitioners, often for diagnostic tests, or to discuss different treatment options, though patients themselves mediated these referrals:

At a couple of stages [my acupuncturist] recommended getting such and such tested or ... things that she wasn't capable of doing. – Lana

My naturopath told me to go see Dr Kim at the health centre... I was surprised actually when [she] said 'you know it's time for you to go to the fertility clinic, discuss the options. I know you don't want to take Clomephine [a widely prescribed fertility drug used to promote ovulation] but perhaps it's something that we have to consider. – Kate

Most participants had the sense that the integration of CAM and conventional healthcare was currently achieved on an individual level, mediated by patients themselves. Nevertheless, an aspiration for a more pluralistic health system, with greater integration of acupuncture and other forms of CAM was clearly articulated:

I think that's... the way the world is going to end up... there'll be clinics where there they'll be working alongside each other, refer backwards and forwards. And it think that would be really quite nice, to be perfectly

honest... Because I do think there is a certain need for both sides [CAM and biomedicine]. – Sarah

[In China] you can go [to the hospital] and get acupuncture, you can get Chinese herbs, but you can also get Western medicine... it is very present that they accept both ideas and... integrate [them]. And you know, China is the future, so I mean if they have anything to do with it, I'm sure both systems will be integrated [elsewhere]. – Poppy

[Acupuncturists] should be capable and qualified of diagnosing and treating anyone [referring to the] relevant person for that stuff that they... can't treat or that they haven't been able to diagnose. Just the same as the medical profession. – Jeremy

I would like to see acupuncture in our hospitals, as it is in China and other Asian countries... alongside Western [medicine]... in my ideal world, that's what I would see... not just necessarily acupuncture... [I'd also like to see] traditional Māori therapy being used in hospitals as well. I think our hospitals should be more holistic because [currently they are not] healing place[s]. – Rose

4.5.3 Perceived practitioner attitudes

This subtheme relates to how participants perceived the attitudes and opinions of their practitioners towards other modalities, for example how their GPs regarded acupuncture, or how their acupuncturists viewed other types of CAM. A number of those interviewed indicated that these perceptions exerted some influence over their health-seeking behaviours.

Biomedical practitioners were thought to have quite varied opinions towards acupuncture and other forms of CAM ranging from negative or dismissive, to neutral, to quite positive:

I'm [working] in the medical world [as a sonographer], and sometimes [doctors] make me feel like I'm some kind of crazy hippy. I am not... I feel like they're a bit judgemental. – Kate

The younger generation of medical practitioners is starting to realise that people don't always want a pill to fix it, [and are more accepting of CAM] – Holly

[I made] a big list of all the alternative stuff I was going to have and [my specialist] was more than happy to do that... As long as I stopped it 24 hours before the chemotherapy and started no more than 48 hours after... he's fairly open that way... he's more than happy about me using acupuncture as well – Sarah

Predictably, those practitioners with explicitly positive attitudes towards acupuncture seemed more likely to encourage its use, which for some participants resulted in referral on to an acupuncturist. A more surprising finding was that GPs expressing dismissive or adversarial attitudes towards CAM had the paradoxical effect of pushing some patients away from biomedicine, or at least from those particular practitioners:

I guess for one thing, doctors don't even really consider it do they? Well my one doesn't anyway, which is why I don't go to her anymore. – Lana

There was a period of time I didn't have a GP... [I was] disgruntled... there was probably five years or so where I didn't see a GP, so I'd go and see an acupuncturist or an osteo[path] or something. But the thing is I found one that I do like, who is supportive of [my use of acupuncture]. – Merida

It has to push me away because they've given me no alternative... I was treated like some sort of crazy girl... I get a vibe... two very unprofessional comments from the [doctor] during the consultation... that was bad. [She said] 'God you're on a lot of vitamins and herbs, that will be expensive!' And so in my head I thought 'IVF [In Vitro Fertilisation] is gonna be very expensive', and I say to her, I was like, 'yes, yes expensive, and I've heard it all before, but this is something I feel happy to do. – Kate

Jeremy discussed his perceptions of biomedical practitioners' attitudes both from the perspective as a patient and allied health professional, speculating that negative attitudes towards other modalities was often related to lack of knowledge and protectionism, rather than concerns for patient safety:

We get it with surgeons ... that say 'oh don't go to physio they're just gonna swing on my new surgery and rip the stitches.' ... how ludicrous is that? ... [Similarly] they don't understand the mechanism of the treatment of acupuncture so therefore [they think] it doesn't work... The more comfortable you are with yourself and your own skills, the more likely you are to accept that someone else has something to offer. And the more protective or worried that you are that that you'll get found out for what you're doing or not doing, the less likely you are to refer and to pass on to someone else.

Whereas practitioners' expressly negative attitudes generated a lot of dialogue and often were rather polarising, for the most part, biomedical practitioners were described as conveying neutral or rather ambivalent towards acupuncture and most other forms of CAM:

[She] didn't encourage me to see the acupuncturist but didn't... discourage.

– Tessa

They don't inquire or want to know a lot about it... they are supportive... but they don't ask in great detail what the other person is saying or doing. –

Merida

While perceptions of biomedical practitioners' attitudes were couched in terms of the "acceptability" of CAM, overwhelmingly, participants seemed to assume that CAM practitioners accepted other forms of healing including biomedical and other CAMs: 'I guess perhaps they're a bit more open-minded of other types of... medicine' (Ella)

Where practitioners were perceived to be supportive or accepting towards the use of other modalities, participants spoke of their experiences in the most positive terms:

[My midwife] is really good, like she's pretty open minded... even last week with my high blood pressure I said ... 'I'd quite like to do acupuncture for it' and she said well 'that's a good idea to explore', so she's quite positive about it all... [My acupuncturist] initially had a medical background. She kind of compares the scientific [medicine] and Chinese [medicine]

approaches]... she gives you alternatives as well so she kind of explains what a doctor might have done [for a particular problem]. – Lana

[My oncologist] was quite happy about it... he suspect[s] the Herceptin [a drug used in the treatment of certain breast cancers] doesn't get affected [by the herbal medicine I was taking]. And he was more than happy for me to try it cause he knows I've been having so much trouble... with my sinuses... he's more than happy about [my use of acupuncture] as well... I was just lucky that he seems to be one out of the box... We click... he's really good in the hospital I think he's kind of got that balance of being very supportive... [and] very honest – Sarah

[My doctors have] all been really good. Well actually I've probably had referrals from maybe two or three, but then I go to doctors who are open minded and who have a interest and respect for alternative therapies so that's probably been helpful for them and for me – Rose

4.6 Health beliefs

Other themes have already conveyed to a certain extent how many implicitly held health beliefs influenced participants' usage of acupuncture. The purpose here is to provide an overview, and to focus on the health beliefs that were openly articulated during interviews.

4.6.1 Understandings of health

A view that was expressed in many interviews was that health is a multifaceted state and one to be necessarily distinguished from the absence of disease or diagnosed illness:

We often think of it as sort of a physical thing, with health. But ... it's on so many levels, it's mental, physical, emotional, spiritual, and they're all connected, they're all connected. And I think, and I've always known this on my own sort of journey. – Amanda

This perspective inherently affirms the concept of holism, indeed Amanda went on to say, '[acupuncture] kind of got me deeper into studying health from a very much from a holistic perspective.' In conveying holistic conceptualisations of health, several interviewees viewed health and illness as a dynamic balance or equilibrium, cyclical and fluctuant, rather than a static binary. Additionally, many facets of health, and by implication, illness were thought to be interdependent. Poor mental health for example, was thought to exert an influence on physical health and vice versa:

How you're feeling... on an emotional level and on an energetic level... if you're feeling tired... sad, [or] depressed, coupled with an exterior environment... dirty air or water... I think that those two things kind of combine to... ultimately [cause] disease and sickness... the most common thing for me and... my friends and family around me, every time someone is really stressed, or having a hard time, or depressed you know, they're gonna get [physically] sick, or I'll get sick. – Poppy

My body was breaking down, my body was sick, because of mental and physical and emotional stress. So it definitely was part of a number of things I think that really started me on [a healing] journey. – Amanda

Given these perspectives, the emphasis placed on the more 'controllable' factors that impact health, such as diet and lifestyle, was unsurprising. Preventative approaches and the importance of personal responsibility were thus underscored:

I guess when you hang around long enough, you get to know that if you get a rash, there's some reason for it... if you've got scurvy, you know that you've got to eat oranges and things like that because of the vitamin content... I think, you know medicine is starting to accept the fact that we are what we eat, what we assimilate and what we eliminate. – Holly

I realised that if you wanna make change in your life, you have to put the work in. It takes time, it takes commitment, it takes effort. And it takes a hell of a lot of patience. – Amanda

I guess just kind of being emotionally... intuitive and aware and doing activities like meditation and yoga so that you have a means with which to kind of balance out your emotions [to maintain good health]. – Poppy

Notwithstanding a generally holistic orientation, participants were not dogmatic; many also acknowledged the utility of more mechanistic or reductionist understandings of illness, particularly in relation to the diagnosis and treatment of conditions with very discrete aetiologies. Jeremy for instance, who had acute musculoskeletal injuries treated with acupuncture provided this perspective:

The way I've sort of worked through it in my brain... most of the injuries I've had there has been a mechanical cause... that I can that I can attribute the injury to. And that follows a basic... stress-to-resilience model, see-saw,

that when the stress overcomes your resilience you [will develop] your injury.

Many also felt that their acupuncturists tended to view these types of problems in such terms: 'She's treating the whole body, apart from the time when she was treating the injuries from the accident' (Sarah). Different ontological perspectives were thus thought to serve specific purposes and as such were considered tools—valid to the extent of their usefulness:

We're not talking about science and religion here. They're both sciences... they just have... a different mechanism or a different understanding of how or why they work. You know, some [aspects of healing] will be a mechanical thing whether you explain it mechanically or not. And some things will have another way of working, whether we explain it mechanically or not. – Jeremy

4.6.2 Healing and healthcare

Reconciling divergent ontologies also engendered an acceptance of, and indeed preference for pluralistic approaches to healthcare—the general assumption being that no model of healing could have all the answers, and that each had its appropriate place. Not only did participants reconcile apparently divergent belief systems and therapeutic approaches for themselves, several also felt that the rift between biomedical and CAM paradigms was slowly being bridged on a more global level:

Whereas they used to be polar opposites, I think science is actually starting to take notice of that now. It's like science is turning around and saying 'oh

you guys... were right all along.' And I'm starting to hear that more and more ... They're definitely getting connected I think. – Amanda

Biomedical treatment was invariably thought to be the most appropriate form of care for acute and serious conditions, whereas acupuncture (and other forms of CAM) were thought to be most effective for treating some chronic, non-life-threatening and quality-of-life-related (QoL) conditions; promoting well-being and resilience; and filling in the 'gaps' left by biomedicine:

It depends on how far advanced the illness is... if someone needs a kidney transplant because they've completely screwed up their kidney or liver... they've gone so far in the direction of sickness that they don't have a lot of options [other than biomedical treatment]. – Poppy

I think for certain diseases of course you do need the sort of hard-out ... medicine-based... treatment, particularly for accidents and acute [i.e. serious illnesses]. – Rose

If I get squished on the road, there's no way I can put myself back together but once I'm stitched up and all the bits are joined up again I can then help my body to heal with nutrition, and the acupuncture – Holly

[If I had not had chemotherapy] I don't think I'd be here today to be perfectly honest... But... [herbal medicine and acupuncture] helped me... tolerate the side effects fairly well and I think it was you know having that support... all the stuff she was giving me was helping to support my body while it was going through that. – Sarah

I think particularly for chronic disease[s]... acupuncture, food therapy, qìgōng... yoga, all of those things are so crucial for the whole being. – Rose

These comments also allude to an expectation that given favourable circumstances, healing can and does occur, and that this healing occurs through the volition of, in Holly's words, 'energy flowing'. Acupuncture's benefit was thus thought to lie in its ability to support the body's natural healing processes. Some went on to explain in more detail how they supposed acupuncture worked, frequently synthesising elements of both biomedical, and traditional Chinese explanations:

I can't really explain it scientifically but from what I understand it's about I guess channelling... the flow of internal things so that they are moving around your body properly so you use different [acupuncture] points to get things flowing in the right direction to different areas. – Lana

[Acupuncture uses] pressure points called meridian points in your body. By stimulating certain points you stimulate certain nerves—you can either increase its sensitivity or decrease its sensitivity and I believe what they're doing is in my case they're actually desensitising the nerve and I've got far more movement than I've ever had in my shoulder and I think that's how it worked. - James

It focuses on releasing pressure in nerves and muscles in the body. – Tessa

Most of the treatment I've had has been fairly topical to the region [of injury]... I clearly don't understand the mechanism [from a traditional Chinese point of view]... but there has to be a chemical change, nervous

system change... I don't fully understand it... when you stick the needle straight in the tendon, just the same as if we hold it with a thumb for a while or massage the area... a decrease in sensation from the area [occurs].

– Jeremy

Those who had been receiving acupuncture on a long-term basis tended to articulate a more nuanced understanding of Chinese medicine theory, using specific terminology such as *qì*, *yīn/yáng*, etc. Others also drew parallels with other CAM systems such as Ayurvedic medicine or naturopathy:

It's something I've always believed. You know, when you talk to most people, it's really funny ... I think a lot of people know, and a lot of people talk about energy, and they understand energy... I talk to so many people about alternative medicine and things like that so they get it... in yoga we talk about... the *chakras* and the *nadis*⁵ and in Chinese medicine it's the meridians, so it's that energetic body. – Amanda

Amanda's comment conveys the impression that various forms of CAM are bonded by shared, albeit idiosyncratically expressed vitalistic philosophies.

The majority of participants resonated to some degree with different versions of vitalism, which with respect to healthcare engendered a preference for as little intervention as necessary, i.e. an inclination towards therapeutic conservatism. Biomedical approaches were sometimes thought to be unnecessarily heavy-handed, or a 'last resort' approach:

⁵ In yogic/tantric traditions, *prana* (vital force) is thought to move through the subtle body in channels called nadis and coalesce in vortices called Chakras, which might be analogous to major acupuncture points.

I would use it if everything else I'd tried hadn't worked—and your quite serious kind of danger of ill health. – Ella

If I've got an infection I'll soak it in salt water and things first and if it doesn't improve of course you've got to seek perhaps some other help. – Sarah

As previously indicated (cf. chapter 4.2), this point of view clearly catalysed some participants' first use of acupuncture, for example by virtue of reluctance to use pharmacotherapeutic interventions to treat symptoms. Reluctance to address illness purely on a symptomatic basis also stemmed from the desire to identify the underlying cause for illness.

4.6.3 A Māori perspective

Rose expressed the view that some of the concepts of Chinese medicine were philosophically congruent with *Māoritanga* (culture, practices and beliefs) and approaches to healing:

[It is my belief that] Pacifica/Māori people are quite sensitive to acupuncture... we have a word in Māori is called Wairua... [wai is] water or 'the Energy' [i.e. qì] and... rua being 'the Two'... [i.e. yīn/yáng].

Rose's use of *wairua* emphasised her understanding of qì as a fundamentally spiritual force; additionally she explained that wairua was the aspect of health she valued most personally. She went on to explain that her views on Chinese

medicine philosophy (and their relevance to Māori) had been formed both by her own experiences and from having had discussions with Māori healers⁶:

Whilst it's different languages and different cultures, we really felt that there was... intertwining of the two meanings. I've had discussions with a variety of different Māori practitioners over the years... [they have] the same feeling [that Māori healing has many parallels with Chinese medicine].

4.7 Chapter summary

This analysis has presented how and why participants used acupuncture; provided an overview of how treatment was experienced and its effects; discussed some aspects of the broader health system that impacted on their experiences; offered insight into participants' personal health beliefs and how these beliefs influenced their usage of acupuncture; and briefly has considered a Māori perspective.

⁶ It was not clarified whether Rose was referring to Tohunga (practitioners of Rongoā Māori, the traditional healing system of Māori), or healers/healthcare professionals who happened to be Māori, or both.

5. DISCUSSION

5.1 Introduction

This chapter's aim is to discuss the themes and concepts that emerged from data analysis and to explore these findings in relation to extant literature. Whilst this study focuses explicitly on acupuncture, it was clear from the results that participants often grouped acupuncture alongside other forms of CAM, conceptually distinguishing it from biomedicine, thus discussion includes reference to what is understood of acupuncture specifically and the broader domain of CAM research. The chapter is divided into five sections closely mirroring the main themes of chapter four: usage, components of therapy, effects of treatment, health beliefs, and the health system.

5.2 Usage

The following discussion examines people's reasons for using acupuncture, the types of conditions treated, and finally some of the factors that impacted access and their possible influence on usage patterns.

Previously, research around the reasons for people's usage of CAM has often been discussed in relation to "push" and "pull" factors, i.e. those that push patients away from conventional medicine and those that pull people towards CAM. Heuristically the push-pull argument undoubtedly has some utility, however this study has reinforced Low's (2004), findings that peoples' reasons for using a given therapy is often more complicated than this binary would suggest. This study has shown that there are a number of prerequisite factors motivating patients to seek acupuncture: firstly the presence of a condition that is perceived to need treatment; secondly, the belief that the intervention might

be helpful; thirdly (when a plurality of modalities are available) there is a reason to choose acupuncture or an acupuncturist instead of other modalities or practitioners; and finally have the available resources to facilitate access.

In several respects this analysis is consistent with the sociobehavioural model that has been used in overseas research to explore usage both of CAM (Sirois & Gick, 2002) and acupuncture specifically (Upchurch et al., 2008). This model proposes that health service utilisation is a function of individual, societal and health services system determinants (Andersen & Newman, 1973). Within a local context, studies have thus far been rather crude in their accounting of patients' reasons for CAM use. In the New Zealand Health Survey 2003-2004 for example, referral by a friend or relative was indicated as a reason for CAM use, whereas examining the interaction of the various determinants described above provides a more nuanced framework and illustrates how a single factor like referral, in and of itself, is insufficient to motivate access and cannot strictly be considered a reason for use. Given the methodology and sample size used in this study a discussion of societal determinants would be going beyond the scope of the data in this study and thus has been set aside. Individual and health system determinants are however discussed throughout this chapter and more comprehensively in sections 5.5 and 5.6 respectively.

5.2.1 Conditions treated

Although participants in this study had used acupuncture for a relatively broad number of applications, the types of conditions treated were alike insofar as they often related to pain, mental health or were the types of conditions that are typically difficult to treat with biomedical approaches. This has been a recurrent theme in CAM research and it is well documented—and

unsurprising—that people often seek alternative approaches for the treatment of conditions that tend not to respond well to conventional medical treatment (Barnes, Powell-Griner, McFann, & Nahin, 2004; Burke, Upchurch, Dye, & Chyu, 2006). With specific reference to acupuncture, Upchurch et al. (2008) found that female patients in the US often sought treatment for back problems, various types of pain and chronic conditions such as fibromyalgia, and similarly in the UK the most commonly treated problems are musculoskeletal (38%), psychological (11%), general health (9%), neurological (8%) and gynaecological/obstetric (8%) (MacPherson, Sinclair-Lian, & Thomas, 2006). Both these studies support the proposal that acupuncture usage probably reflects that of CAM as an aggregation (Burke et al., 2006; Sherman et al., 2005). Whereas these population-based studies necessarily illustrate a ‘snap-shot’ and are generalisable to some extent, this study offers some original insight into how patients’ usage can change over time. As indicated previously, increased familiarity with acupuncture led several participants who originally only considered its application for the treatment of a very narrow range of (usually pain-related) conditions, later went on to choose acupuncture for a more diverse range of problems.

5.2.2 Reasons for use

To reiterate, most participants in this study largely described their initial use of acupuncture as pragmatic, i.e. in seeking a satisfactory solution to a given health problem where they had found biomedicine to be ineffective. While this was a source of dissatisfaction and an important catalyst in participants initially seeking acupuncture, in many respects it simply reflects the therapeutic limitations of medicine. This theme is largely consistent with the findings from

Low's (2004) qualitative study of CAM users who actively sought CAM when conventional medicine had failed.

Some participants' general indisposition towards pharmacotherapeutic interventions stemmed from concerns around the potential adverse affects of medication. Previous studies have similarly highlighted such misgivings among CAM users, even in those ensconced in biomedical care. Carpenter et al. (1998) for instance showed that breast cancer survivors with post-mastectomy pain often did not want pharmacological treatment for pain, believing that the analgesic effects were not worth the risk of longer-term adverse reactions from medication.

The current study also indicates how dissatisfaction with pharmaceutical treatment may relate not only to ineffectiveness or patients' concerns about safety, but also to personal health beliefs and particularly the ontology of illness. While health beliefs were not always explicitly acknowledged as a reason for participants' initial use of acupuncture, they did implicitly underlie scepticism towards aspects of biomedicine, particularly reductionist conceptualisations of aetiology, illness, and approaches to treatment. It repeatedly emerged for instance that participants felt that biomedical modes of practice sometimes fail, for want of an adequate investigation of the underlying causes of illness, to reach a satisfactory treatment plan. People who use other forms of CAM, such as homeopathy have shown similarly sceptical attitudes towards biomedicine (Furnham & Kirkcaldy, 1996), suggesting certain philosophical commonalities among the users of different forms of CAM. Accordingly, it has been posited that people attracted to CAM share some universal ideological characteristics such as a holistic worldview and an interest in spirituality (Astin, 1998).

While participants' usage of acupuncture changed over time (particularly in broadening its application), so too did their apparent motivations for continuing its use. This is in keeping with other studies that have found patients reasons for using CAM therapies to have a temporal aspect—with increased knowledge and experience, positive factors (i.e. pull factors) become increasingly influential (Sirois, 2008; Vincent & Furnham, 1996). Like those in Cassidy's (1998) study, participants often came to value the closer and more horizontal patient-practitioner relationship with their acupuncturists and the implicitly empowering dynamic that such a relationship generates.

5.2.3 Access

The factors impacting access were highlighted in chapter 4.2. To recapitulate, GPs, other CAM practitioners, family, and friends were identified as the main sources of information, or referral pathways leading participants to acupuncture.

As the first port of call in healthcare for most people, GPs' familiarity with acupuncture and comfort in recommending its use for certain conditions undoubtedly exerts an influence in the way patients use it. Indeed it has previously been shown that patients' views on the appropriateness of different CAMs for particular conditions seem to generally reflect those of their doctors (Eisenberg et al., 2001). While a range of attitudes were perceived by participants, (cf. chapters 4.5, 5.5), GPs have clearly met acupuncture with comparative enthusiasm, or at least acceptance (Poynton et al., 2006), and as the most widely practiced form of CAM in general practice, it is often employed to treat musculoskeletal disorders and chronic pain syndromes (Marshall et al., 1990). A significant percentage of GPs in New Zealand also seem happy to refer

their patients to acupuncturists. In a nationwide study (Poynton et al., 2006), 79.3% of GPs reportedly referred patients for acupuncture. Though its mode of action has only been partially explained from a biomedical perspective (for example, using endogenous opioid mechanisms as explanatory models (Holden, Jeong, & Forrest, 2005), acupuncture's appropriation as a technique pruned from its traditional theoretical roots (Cheng, 2011; Vickers & Zollman, 1999) has frequently facilitated its redefinition within a biomedical framework (Dew, 2000; Wolpe, 1985), assuaging many doctors' (and perhaps patients') discomfort with an intervention underpinned by an ontological paradigm inconsistent with that of contemporary biomedical thought. While GPs' opinions are important to many people, it should be noted that CAM usage and perceived effectiveness are not necessarily coterminous (Stoneman, Sturgis, & Allum, 2012). There are other factors that influence the types of conditions for which people seek to access acupuncture that may be as, or more important, than supposed efficacy or medical judgment. The New Zealand Health Survey 2003-2004 in fact found that only about a third of adults who had visited a CAM practitioner had also consulted a GP about the same condition (MACCAH, 2004). Friends and relatives emerged as important 'referrers' in this study and have been identified as an influential source of information regarding CAM use previously (De Bruyn, 2001; Fulder & Munro, 1985; Hedley, 1992; Sharma, 1989; Wellman, 1995) hence, while scientific evidence and theoretical congruence might be important in doctors' inclinations to recommend therapies for particular problems, they are clearly less important to patients. Personal stories and anecdotes were persuasive for participants in this study and have been shown to be influential in patients' decision-making processes elsewhere in the literature (Evans et al.,

2007). This has led some commentators to posit that CAM use is predicated on lack of knowledge, and that users are either ignorant or mistrustful of science (Beyerstein, 2001; Stoneman et al., 2012). However demographics with high levels of education (Astin, 1998; Bains & Egede, 2011; Hämeen-Anttila, Niskala, Siponen, & Ahonen, 2011; McFarland, Bigelow, Zani, Newsom, & Kaplan, 2002), and biomedical professionals themselves (Johnson, Ward, Knutson, Knutson, & Sendelbach, 2012), are more likely to access CAM than the general population, which makes such an assertion seem unlikely. Certainly most participants in this study had high levels of education and health literacy and while several were sceptical of specific aspects of biomedicine, they were not particularly 'mistrustful' of either medicine or science generally.

Irrespective of the inclination to use acupuncture, this study has underscored a number of 'enabling factors' that facilitate access and particularly the ability to pay for treatment. The OPP cost of CAM has regularly been cited as a deterrent factor for those seeking treatment (Andrews, 2002; Bishop, Yardley, & Lewith, 2010), as it was for a number of participants in this study. This has also been posited as an explanation for the higher prevalence of CAM use amongst populations of higher socio-economic status (SES) (Eisenberg et al., 1993; Fulder & Munro, 1985). Since ACC covers all New Zealanders for accidents and injuries, the financial barriers to accessing acupuncture are potentially reduced, availing it as an option for a greater proportion of the population for a given number of conditions (see Appendix I) than might otherwise be the case. However, many participants clearly were not aware of the funding streams available for acupuncture (for example from private insurance, quasi-public funding via ACC, Work and Income New Zealand (WINZ), or other agencies) and

overseas studies have shown that lack of awareness of available services can encumber access (Bishop et al., 2011). Ability to pay did not affect participants' decision to use acupuncture so much as it did the frequency of access. Consequently, it is possible that patients do not receive the appropriate 'dosage' of acupuncture, which raises questions about equity. If, for example, there is evidence to suggest that a certain number of treatments are necessary for a given condition, funding structures should reflect this need to avoid under treatment and facilitate optimal patient outcomes.

From the above discussion it follows that acupuncture patients are similar to other CAM users in that their initial usage is often motivated by dissatisfaction with conventional approaches to healthcare due either to its ineffectiveness for particular conditions, or because it conflicts on some level with their personal health beliefs. The types of conditions treated with acupuncture are also generally similar to CAM, though the range of conditions treated may increase with greater exposure to treatment. Finally, it is clear that there are several health system factors that impact access, particularly dissemination of information, referral pathways and funding. These issues warrant further research in order to inform effective policy and funding for agencies like ACC.

5.3 Components of therapy

This section sets out to discuss patients' conceptualisations of the various components of therapy with comparisons made to extant research, and suggests how the assumptions underlying acupuncture's theoretical paradigm impact on how the therapeutic encounter is experienced. Additionally it begins to raise

insights into how some of the components of therapy can influence treatment outcomes before a more detailed analysis is developed in the following section.

As highlighted previously a great deal of significance was attached to the intake processes during acupuncture sessions and in keeping with other studies (Griffiths & Taylor, 2005; Rugg et al., 2011), participants characterised the intake as being very comprehensive and one which allowed them to simultaneously address multiple facets of health during the consultation. This thoroughness may be a function of a number of factors but most obviously relates to some of the assumptions inherent to traditional Chinese medicine, particularly the importance of perceiving the body's patterns in their entirety rather than isolating its parts (Neal, 2012), where an overall picture of health is privileged over reductive analyses. The Daoist philosophical context in which Chinese medicine developed also influences its practice by virtue of its emphasis on the reliability of human experience (Kaptchuk, 2002) so that practitioners tend to rely on the information that can be gathered through traditional observational methods i.e. inspection⁷, auscultation⁸, olfaction⁹, inquiry¹⁰, and palpation¹¹ (Xinnong, 1987). This makes for a time consuming process and requires the examination of many different aspects of health including extensive questioning

⁷ This involves observing the patient's complexion, vitality, appearance (i.e. the body shape, posture, movement patterns, etc.), and sense organs (eyes, ears, nose, gums, mouth, throat and tongue).

⁸ The speech (coherence, volume, cadence), respiration and cough (if one is present) are all used diagnostically.

⁹ Body odour, breath and any wounds might be used for diagnostic purposes.

¹⁰ This is possibly the most important aspect of the diagnostic process. Customarily seven main areas guide practitioners' questioning. These are: chills and fever, perspiration, appetite (including thirst and taste), defecation and urination, pain (its character, location, aggravating and ameliorating factors), sleep and menses.

¹¹ There are four main aspects to palpation: the site of injury or dysfunction, the abdomen, key acupuncture points and, the radial pulse. The injury site, abdomen and key acupuncture points are palpated for irregularities such as heat, swelling, tension, masses and pain, while the pulse represents an elaborate diagnostic tool in itself (cf. chapter 4.3, footnote 4).

into aspects of emotional, lifestyle, and other factors (Liangyue et al., 2001, pp. 254-261).

While traditional diagnostic techniques have some obvious and serious limitations, this research highlights some of the benefits they confer. The high degree of personal interaction present seems to be instrumental in engendering patients' sense that their care is both individualised and holistic. Reflecting on the following three excerpts (the first from a participant in this research, the following two from studies included in the literature review) also illustrates how the diagnostic process can play a powerful role in inculcating patients' sense of feeling understood:

We sat and had a huge chat, and talked about a lot of things that were going on in my life and about my work and about things that were coming up... she just seemed to understand where I was in life... And I think that really sort of helped. – Amanda

She was the first person that I'd told the whole story to. It felt like I was telling her everything and letting her take the burden for a bit, as if I had given it all to her (Paterson & Britten, 2008, p. 268).

I feel [the intake interaction is] a really positive thing; it felt like it was part, part of the healing process (Rugg et al, 2011, p. 309).

Following on from participants' descriptions of intake processes were those of specific techniques used during treatment. Needling, the procedure most visibly associated with acupuncture, is itself clearly an important aspect of treatment and is used in almost all sessions (Sherman et al., 2005), yet while some

participants experienced quite considerable effects that they attributed to the needling process, most discussed this aspect of therapy rather perfunctorily in terms of the sensations produced (aching, tingling, shooting sensations or pain, for example) without going into any great detail. The same could be said of other supplementary techniques such as moxibustion and the prescription of herbal medicine. It may be the case that this simply reflects the direction taken during interviews, indeed the research question is in some respects one of breadth rather than depth, however similarities can be drawn to Hughes' (2009) study where patients receiving traditional acupuncture tended not to focus on specific techniques, but emphasised other aspects such as the therapeutic relationship with the acupuncturist, treatment setting, and lifestyle changes they had made based on their practitioners' recommendations.

This study is also consistent with Hughes' in that self-care strategies held a considerable degree of significance for many participants – as illustrated by Rose's comment that her practitioner gave her the 'tools' to change her life in a positive direction, for example. Just as I have argued that acupuncture's explanatory theoretical model influences patients' experiences of the intake process, it follows too that patient education and self-care strategies are similarly influenced. Cassidy (1998) has previously conveyed that as a holistic modality, acupuncture emphasises health education and self-reliance, implicitly establishing practitioners in the role of teacher/facilitator. It is perhaps for this reason that many participants also accented the attributes of their acupuncturists and their relationships with them.

Mitchell, Cormack and Reilly (1998) describe what they view as essential attributes for health practitioners including warmth (unconditional positive

regard), empathy (accurate listening), and genuineness (openness). These types of qualities are fundamental in order to engage patients' sense of personal responsibility (Gyllensten, Gard, Hansson, & Ekdahl, 2000). Given participants' perceptions and what has already been discussed with respect to the therapeutic model employed in acupuncture, it is clear that practitioners' ability to relate to patients is often an integral therapeutic component. Moreover, their ability to convey empathy has even been shown to be predictive of treatment outcomes (Price, Mercer, & MacPherson, 2006).

The understandings generated from this theme demonstrate that although biomedical conceptions of acupuncture tend to focus almost exclusively on its most visible materialistic aspects—specifically that of needling—patients perceive a much more encompassing system of care—a system that is characterised by a distinct diagnostic and therapeutic framework that emphasises self-care and preventative health strategies, and one in which patient-practitioner relationships are of fundamental importance.

5.4 Effects of treatment

The results presented in chapter 4.4 offer what participants perceived to be the health changes experienced as a result of acupuncture, an area that so far has received relatively little attention in the literature (Alraek & Baerheim, 2001).

This study has shown that patients often experience changes specifically related to their presenting complaint such as pain reduction, mental and emotional changes, and improved function. Previous patient-centred studies have also recorded the symptomatic changes patients say they have derived from treatment: rheumatoid arthritis (RA) patients for instance have reported

improvements in rheumatic pain and mobility (Hughes, 2009); cystitis patients report more complete bladder emptying and reduced abdominal pain (Alraek & Baerheim, 2001); postmenopausal women show a reduction in the frequency and intensity of hot flushes (Alraek & Malterud, 2009); and patients with polycystic ovary syndrome (PCOS) report a reduction in acne and hair growth (Billhult & Stener-Victorin, 2012).

Other changes that participants derived including increased energy, improved sleep, sensations of calmness and relaxation, and a greater sense of well-being are also broadly consistent with the findings of other studies; indeed it is, 'a common experience among acupuncturists and their patients that acupuncture treatment results in a positive effect on health in general, in addition to its intended treatment effect' (Alraek & Baerheim, 2001, p. 219). For example, Ford Geiger (1986) studied 357 acupuncture patients over a two-year period finding that patients, even those who had sought treatment for physical conditions reported feeling 'better', 'calmer', 'relaxed', and 'balanced'. Finding such positive 'side-effects' to be similarly common, Cassidy (1998) developed a schema that conveys patients' experiences of change according to symptomatic, physiological, and psychosocial perspectives (see Table 12).

Table 12 <i>What Respondents Said Chinese Medicine Care Does and Why They Liked It</i>	
Chinese medicine care relieves symptoms and improves function	<ul style="list-style-type: none"> • Relieves physical pain • Relieves or releases emotional pain • Decreases the frequency, intensity or duration of complaints
Chinese medicine improves physiological coping or adaptive ability	<ul style="list-style-type: none"> • Increases energy • Induces sensation of calm, relaxation • Helps reduce reliance on prescription drugs • Reduces the frequency of colds • Strengthens the immune system • Speeds healing, such as from surgery • Minimises side-effects of drugs
Chinese medicine improves psychosocial coping or adaptive ability	<ul style="list-style-type: none"> • Increases self-awareness • Engenders a sense of wholeness, balance, centeredness, well-being • Increases self-efficacy • Changes lives

(Note. Adapted from Cassidy, C. M. (1998). Chinese medicine users in the United States Part II: Preferred aspects of care. *Journal of Alternative and Complementary Medicine*, 4(2), 189-202)

This schema encapsulates many of the symptomatic changes encountered by participants of this study that have already been discussed, reinforcing Cassidy's findings and validating them in the context of a different culture and health system.

Many of the broader effects described in chapter 4.4 reflect other authors' findings that patients sometimes undergo changes in understanding or attitude as a result of treatment: for instance the ability to take greater personal responsibility for health, better decision making skills, and a more holistic outlook on life (Gould, 1999). Based on such understandings, patients often re-evaluate their circumstances and change behaviours accordingly (Rugg et al., 2011), sometimes making major life changes. The shifts described by Gould also

correspond closely to those described by Cassidy's as psychosocial coping or adaptive ability changes.

It has been noted that patients and physicians can often make quite different assessments of the benefits and outcomes of therapy (Hall, Horrocks, Clamp, & De Dombal, 1976; Orth-Gomer, Britton, & Rehnqvist, 1979; Slevin, Plant, Lynch, Drinkwater, & Gregory, 1988). The discussion above indicates that many of the changes experienced as a result of acupuncture place the patient as arbiter of their own health/illness and are thus necessarily subjective, and often multi-dimensional. It is for this reason that several participants felt that these effects might be hard to measure. As an emergent theme some discussion of research methodologies is warranted in order to reveal if and why this might be the case.

As delineated in chapter 2, the evidence base for acupuncture is tenuous for all but a very small number of conditions and yet patients often seem to derive significant benefit from treatment for a much wider range of problems. It is entirely possible of course that systematic reviews have rightly concluded acupuncture to be inefficacious much of the time. However, a brief analysis of where biomedical and Chinese ontologies diverge offers some alternative explanations for this apparent contradiction. Acupuncturists have widely espoused the notion that Chinese medicine does not treat diseases; rather the practitioner differentiates patterns of disharmony (Erikson, 2012). According to this model of practice, various symptoms are not isolated from each other, or from the patient in whom they occur and, 'no single part can be understood except in its relation to the whole' (Kaptchuk, 2000, pp. 6-7). Patients' experiences show that treatment is usually highly individualised, and from

practitioners' point of view therapy is directed at addressing patterns of disharmony rather than a singular presenting complaint (i.e. a defined disease or condition).

Using the example of RA, it becomes clearer how this divergence is problematic with respect to trial design. While RA is a well-defined (albeit poorly understood) autoimmune disease (Feldmann, Brennan, & Maini, 1996), from the perspective of Chinese medicine, RA may present as five or more different patterns (Flaws & Sionneau, 2001) with an equal number of possible treatment approaches. In Hughes' (2009) study, RA patients received "normal" (i.e. highly individualised) care, based on pattern differentiation, whereas patients in each of the RCTs included in Casimiro et al.'s systematic review of acupuncture for RA (Casimiro et al., 2005) were treated with a standardised protocol (though each RCT within the review used different protocols, which is another methodological issue in itself). In light of this divergence, there is clearly some justification in the contention that clinical trials do not provide appropriate model fit validity for acupuncture as it is traditionally practiced (Birch, 2004; Cassidy, 2009; Long, 2002; Verhoef et al., 2005).

There are also methodological issues that relate to research design in acupuncture RCTs and the assumptions underpinning their use. RCTs are largely premised on the assumption that the active component of treatment can be reduced to the needling of specific points, in the same way that the active component of a drug can be isolated. Accordingly, the various approaches used to achieve a suitable placebo have included needling "inactive" or non-

acupuncture points¹²; minimally inserting needles (i.e. 1-2 mm depth) rather than to a depth that achieves ‘*dé qì*’ (distending or aching sensation)¹³ or using a sham needle called the Streitberger needle, with a stage dagger-like design whereby the shaft of the sham needle slides into the handle upon “insertion”. This heterogeneity in trial design (as well as the ongoing debate over what might be considered an acceptable placebo) calls into question the validity of many conclusions drawn about acupuncture’s efficacy. Indeed it is a common theme in systematic reviews of acupuncture that trial heterogeneity makes unequivocal conclusions impossible to draw. In some clinical trials acupuncture has clearly been effective – even more so than the standard (ostensibly evidence-based) pharmaceutical interventions – and yet has been deemed inefficacious in what Walach (2009) has termed the *efficacy paradox* for failing to produce statistically significant superiority against its placebo control (for example, Cherkin et al., 2009; Haake et al., 2007; Scharf et al., 2006).

Recently some researchers have adopted a novel perspective by considering the possibility that placebo is a rather more nuanced phenomenon than has previously been entertained. In an innovative study designed to compare two placebo interventions, it was shown that sham acupuncture had a greater effect on pain relief than a placebo pill, indicating that the placebo effect

¹² Definitions of what constitute acupuncture points can be contentious and needling strictly anatomically defined locations does not necessarily reflect the reality of practice. Many practitioners use anatomical landmarks only to guide palpation in defined areas for specific qualities (such as irregularities in texture, temperature, tenderness and so on). Consequently standardised locations may not be true representations of traditional acupoints. Conversely, needling non-acupuncture points cannot be considered an entirely physiologically inert process. This situation potentially results in stimulation of non-points that are supposed to be active and vice-versa.

¹³ This approach assumes that ‘*dé qì*’ is prerequisite for therapeutic effect, whereas not all techniques, acupoints or styles of acupuncture indicate this as a necessity. In fact, there is a large degree of disagreement over both point selection and needle technique (Birch, 2004) raising the question of whether shallow needling can be considered a valid placebo.

is malleable and dependant on the behaviours incorporated in the therapeutic exchange (Kaptchuk et al., 2006). It is conceivable therefore; that the components of therapy, other than the assumed active intervention, can produce valid, meaningful, and specific effects, and that their effects may vary in type and magnitude (Endres, 2009). Certainly, the thematic analysis in this study has reinforced that as a complex practitioner-orientated intervention acupuncture may contain many discrete components (such as the intake process, practitioners' touch, listening, conveying empathy) to which treatment effects might be attributed and have yet to be fully understood.

As the complexities of clinical trial design continue to be disentangled there are some other, arguably more fundamental issues related to the nature of evidence and the validity of RCTs as the gold standard for assessing effect, irrespective of the intervention of interest. Consequently the validity of an evidence *hierarchy* is increasingly being challenged in favour of methodological pluralism (Kahlert, 2012). Whereas RCTs provide average effects for studied populations, these effects do necessarily translate to individuals, particularly when strict exclusion criteria result in narrow patient groups and exclude important populations (Simon, 2001) such as those with comorbidities. Conversely, small-scale and qualitative studies cannot provide statistically significant results but do provide an in-depth picture of treatment effects and the meaning that patients attach to them.

The issues outlined here vindicate participants' intuition that treatment effects are difficult to capture under a biomedical framework. It has been argued by some researchers that acupuncture should be assessed on the basis of whether treatment brings about an improvement in health or quality of life that

is meaningful to the patient (Paterson et al., 2007). To this end, tools like the SF-36 (a patient-reported survey of health) (Brazier et al., 1992), are now established, well validated, and have been used in a number of acupuncture trials (such as Gould, Fitter, & MacPherson, 1999; Linde et al., 2005; Sällström, Kjendahl, Østen, Kvalvik Stanghelle, & Borchgrevink, 1996; Witt et al., 2006). The SF-36 and other instruments that avail patient-centred outcome measures can provide valuable descriptions of health status, while qualitative accounts of patient experiences can contribute to developing instruments that are specifically relevant to acupuncture (Paterson et al., 2007).

This overview has considered treatment effects and demonstrated a high degree of consistency among qualitative analyses of patients' experiences of acupuncture. In addressing where biomedicine and Chinese medicine models differ, it has noted some of the shortcomings of research designs, raised universal questions about the validity of the currently accepted methods, and finally proposed that taking a patient-centred view into consideration can provide a more comprehensive understanding of treatment outcomes.

5.5 Health system and integration

This section provides a general discussion of how participants' use of acupuncture was affected by aspects of the broader health system, and particularly the attitudes and behaviours of other health practitioners. It examines some of the interdisciplinary communication barriers that participants identified and argues that conceptualising the current scenario of dual CAM/biomedical use as one of "integration" is tenuous.

Almost all participants in this study had used a number of different interventions in addition to acupuncture, based on perceptions of their respective utility, and as such were participating in an example of 'integration through consumer choice' (MACCAH, 2004). As the narrative has demonstrated, this model of integration is achieved individually on an ad hoc basis, mediated by patients themselves in the absence of any kind of meaningful exchange between practitioners. This analysis is strikingly similar to previous investigations that have found patients' use of different modalities to be instrumental and concurrent rather than complementary (Low, 2004).

Within the New Zealand health system GPs are often regarded as the gatekeepers and as such their attitudes are important in influencing referrals and access to many health services, including those within CAM (Botting & Cook, 2000). It has previously been shown that patients are less likely to avail themselves of CAM if they think that their doctors are unsupportive (Jain & Astin, 2001).

GPs in New Zealand reportedly have quite positive views of acupuncture (Poynton et al., 2006) and observed consultations have found GPs to be tactful even when their views of particular CAMs do not align with those of their patients (Dew et al., 2008). This study has demonstrated however that patients clearly "read between the lines" in interpreting their GPs' opinions, which fall—or are interpreted as such—on a continuum from ambivalent to explicitly negative. It has also shown that in some instances overt disapproval towards CAM may alienate patients, lead to disenchantment with biomedicine and paradoxically, encourage CAM use in its *alternative* sense. It is of course possible that doctors' attitudes and patients' perceptions of them may not always align. It

is also possible that doctors (and other practitioners) are more circumspect during consultations when they know they are being observed, and the discrepancy between Dew et al.'s (2008) and this study demonstrates the need to triangulate perspectives in order to gain a more comprehensive understanding of the phenomenon.

As identified, lack of inter-paradigmatic communication and referral may be due to practitioners speaking different “languages”. This has been postulated as a barrier elsewhere and predictably, lack of knowledge is inversely associated with referral (Wong, Toh, & Kong, 2010). Doctors have widely acknowledged they are not confident discussing CAM with patients because of lack of familiarity with it (Ernst, 1999; Fearon, 2003; Perry & Dowrick, 2000; Sikand & Laken, 1998). The two GPs who actively and formally referred to acupuncturists in the present study were working in a primary care centre alongside acupuncturists and other CAM providers and had some training in acupuncture themselves. Whether or not this example of practitioner-initiated integration facilitated better communication remains unclear but it certainly seemed to engender a much greater degree of patient satisfaction. Similarly, where other biomedical and allied health practitioners had expressed enthusiastic, or at least non-judgemental attitudes towards the use of acupuncture and other CAMs, participants’ stories typically carried a positive tone and engendered more communicative practitioner-patient relationships.

Although largely prepared to accept the status quo, all participants expressed an aspiration for a more structured and active model of integration, for example through practitioners communicating and collaborating more actively in primary care, or through the incorporation of CAM in hospital settings

wherever appropriate. Participants' resignation to the difficulties of institutionally-driven IM might be prognosticative if previous experiences are anything to go by. Many examples of institution-based IM have for a myriad of reasons had limited success and at times been a 'study of unintended consequences' (Coulter, Ryan, Hilton, Ellison, & Rhodes, 2008, p. 381). With reference to inter-practitioner communication specifically, Faldon et al. (2008) found rather counter-intuitively, that 'incorporating a CAM clinic into the hospital site does not seem to enhance clinical cooperation between conventional physicians and CAM practitioners' (Faldon et al., 2008, p. 212). In fact, in IM hospitals (i.e. those hospitals with CAM clinics in situ), doctors might be appreciably less amenable to cooperation with CAM practitioners than in hospitals without CAM clinics. Recently in New Zealand, Wanganui Hospital's failed attempt to introduce CAM, 'despite receiving overwhelmingly positive feedback' (Emerson, 2012) was met with ambivalent, if not hostile reactions from some quarters, eventually to be scrapped upon recommendation from the hospital's medical staff association. While the rhetoric of IM continues to be espoused as a means to bridge the rift between healing paradigms, it seems to this author that successful integration is, just as most participants in this study concluded, a long way off.

Discourse on IM has largely considered how various CAMs might be integrated/co-opted within the dominant biomedical paradigm. This study has also brought to light a theme that has received much less attention—that of the interactions between various CAM modalities. While participants conveyed the overall sense that CAM practitioners are generally more accepting of other practices than their biomedical colleagues, their referral and communication

behaviours did not reflect this assumption—intra-CAM and inter-paradigmatic communications were similarly exiguous. The lack of communication within CAM is unsurprising when one considers several structural and philosophical factors that differentiate biomedicine and CAM practice.

Firstly, CAM on the periphery of health systems as it is, lacks the frameworks and resources that normally facilitate communication within biomedicine (hospital hierarchies/primary care organisations, and access to electronic health records (EHRs), for instance).

Secondly, while participants tended to believe that various forms of CAM have a sufficient degree of similarity to enable meaningful communication between practitioners, it is unknown whether practitioners themselves hold the same view. Just as biomedical practitioners have expressed reluctance to refer to CAM on the basis that they do not know enough about it (Botting & Cook, 2000; Wong et al., 2010), it is entirely conceivable that CAM practitioners feel the same way about other CAM therapies. Acupuncture and naturopathy, for example, use considerably different diagnostic and therapeutic methods and whether or not practitioners have much knowledge or understanding of each other's modalities is unclear. An interesting and perhaps slightly ironic corollary is that many formally trained CAM practitioners have at least basic (and sometimes extensive) knowledge of biomedicine and thus may be more comfortable communicating with biomedical professionals, and will almost certainly be more familiar with what it is they actually do therapeutically, than with other CAM practitioners. Indeed, in reflecting on my own experience as a practitioner, communication with both biomedical and other CAM providers tends to be in the *lingua franca* of biomedicine.

Lastly, sparse referral between CAM modalities may be explained by some common philosophical tenets. Whereas biomedicine tends to view the body in clearly demarcated systems (which results in a multitude of professional specialties and ensuing referral imperatives), much of CAM, being underpinned by holism, is inclined to conceptualise different body systems and symptomatology as being related and interconnected. Consequently, the degree of specialisation seen in biomedicine is absent in much of CAM. So while certain CAM practitioners focus on particular areas of healthcare, most probably see themselves as generalists. While there is evidence that some CAM practitioners direct their patients to other CAM modalities (Low, 2004; Wellman, 1995), there is very little indication of the extent and form that this type of referral tends to take. It is impossible to know if the results from this study are typical but if they are, intra-CAM referral networks, where they exist, seem to be formed from the bottom up by informal relationships among practitioners and through word of mouth.

Though various options for IM have been suggested (see Appendix L), integration through practitioner referral is already happening in New Zealand albeit in a very limited capacity. Therefore this seems like the most promising and expedient option to pursue at present. The discussion above suggests that not enough is known about how CAM practitioners view and experience communication within their patients' scheme of healthcare. For this scenario of integration to be more successful the first obstacle may be to establish the means for practitioners to share information more easily and develop a better understanding of appropriate referral options. It may also be contingent on the

ability to agree upon a common language with which to share ideas—which given the diversity of CAM modalities would not be an easy task.

5.6 Health beliefs

Health, and by inference illness, are highly individualistic concepts, contextually derived and contingent on personal conceptions and meaning (Furnham, 1994; Muir, 2006). Generalisations are therefore inherently problematic and risk stereotyping. This study has however drawn together some common threads in participants' health beliefs, many of which have already been alluded to throughout preceding sections. The purpose here is to summarise this theme by synthesising a more coherent overview of participants' theories on health, aetiology, and healing and give consideration to related literature.

5.6.1 Understandings of health

The diversity of CAM was highlighted in the introductory chapters of this thesis. This was intended to lend a degree of specificity to the study and in order to prevent generalisations about "CAM ideologies" from biasing emergent themes. It rapidly became clear during data analysis however that many participants indeed felt that various forms of CAM are 'mutually referential' in their holistic conceptualisations of health, and that this holistic outlook was congruent with their personal ideas about health.

Though often casually used for any perspective that sees biomedicine as excessively reductionist (Kaptchuk, 2010), holism can be defined in specific terms—the pivotal tenet being that the 'whole is different from, and greater than, the sum of its parts' (Coulter, 2004, p. 113). With more explicit reference to traditional acupuncture as a model of healthcare, Cassidy (1998) argues that

holism conceptually merges health with well-being, a state encompassing physical, mental, emotional, spiritual, and social components.

The incorporation of a spiritual element in holistic conceptualisation of health might lead to the assumption that “spiritually inclined” individuals are more disposed to its use. Spirituality however, means many different things to different people. For several participants in this study its expression was found through various versions of vitalistic philosophy. Vitalism holds that all living things are ‘sustained by a vital force both different from, and greater than, physical and chemical forces’ (Coulter, 2004, p. 113). While few participants articulated their health beliefs specifically using the language of Chinese medicine, many clearly resonated with vitalistic philosophies and additionally considered this to be a common thread that wove different forms of CAM together (for example, chakras and nadis were explicitly analogised to acupuncture meridians). Though largely abandoned by science, vitalism is an idea that continues to exist in public consciousness (Clark-Grill, 2005) and is an increasingly pervasive ideology in the West (Jonas et al., 2003).

5.6.2 Healing and healthcare

Subscription to holistic and vitalistic philosophies engenders particular preferences with respect to healthcare approaches. Holism emphasises individual responsibility and prevention (Cassidy, 1998) and it has been argued that people attracted to acupuncture and other forms of CAM pay greater attention to the more “controllable” causes of disease such as psychological factors (Furnham, 1994). The conceptualisation of acupuncture as a holistic modality certainly represented a strong pull factor for some participants, particularly with increased exposure to and understanding of its underlying

theories. Conversely, managing isolated symptoms was not always considered to represent a return to health if it undermined the ability to address the causes of illness and was equally a push factor that precipitated scepticism towards reductionist therapeutic approaches. Additionally, concerns about the potential adverse effects of medication were widely voiced, which viewed through the lens of bioethics indicates a strong resonance with the concept of non-maleficence, i.e. that health interventions should, as the first priority avoid causing harm.

If non-maleficence is privileged in such a way, and given the awareness that any kind of intervention inherently carries a level of risk, then it is axiomatic that healing methods should use as little intervention as possible. This refers to *therapeutic conservatism*, and again in many ways typifies the “CAM paradigm” (Coulter, 2004). Notwithstanding an obvious preference for therapeutic conservatism, all participants held quite clear ideas about the appropriateness of different modalities and like other CAM users, had not relinquished biomedicine, but had redefined its role within a broader scheme of healthcare (Wolpe, 1999 Eisenberg et al., 2001). It was universally agreed for example, that when symptoms were acute and immediately dangerous, it was entirely appropriate to treat them with riskier interventions in a more reductionist approach and without having delved into other aspects of health. Conversely, chronic, quality of life and mental/emotional health issues, which afford greater time and the ability to address causal factors without immediate risk of harm, require more holistic approaches. This distinction reveals the substantive difference between disease and illness as understood from patients’ points of view (Cassell, 1976). If biomedicine’s greatest strength is thought to lie in its ability to *treat* pathology, acupuncture’s lies in its facility to *heal* the person.

5.6.3 A Māori perspective

Māori and biomedical (implicitly, Eurocentric) conceptualisations of health are often likely to differ (Durie, 1985). For Māori, the cornerstones of health are 'te taha wairua (a spiritual dimension), te taha hinengaro (a psychic dimension), te taha tinana (a bodily dimension), [and] te taha whanau (a family dimension)' (Durie, 1985). These aspects of *hauora* (well-being) have a striking resonance with the holistic ideologies of Chinese medicine and with many other forms of CAM.

Each of the elements of *hauora* is regarded as mutually interdependent, though Māori widely recognise te taha wairua as the most fundamental requirement for health (Durie, 1985). While the Māori perspective offered in this study compared qì to wairua, a closer analysis of Chinese medicine theory might compare wairua more aptly to the Chinese concept of *Shen*, which though closely related to qì is conceptually distinct:

Shen [spirit] can be thought of as the vibrancy or aliveness of consciousness. It is really more than just consciousness and mental functioning. It is the vitality behind Qì and *Jing* [essence] in the human body. It is the integrative, animating quality we think of as mind, spirit, and intelligence. Shen is not created by an organ, but is part of the vitality of the organism that connects it to the greater universe (Diamond, 2000, p. 63).

Many government-led Māori health initiatives have affirmed the importance of te taha wairua both in health education ("The New Zealand Curriculum," 2007) and within broader intervention strategies (for example, M.o.H, 2006). It is this dimension of health however that is arguably the most difficult to reconcile within biomedical practice, underpinned as it is by an essentially materialist and

implicitly contradictory ontology of health. Accordingly some Māori may feel that certain needs are better met by Rongoā Māori and Tohunga. It also seems that many aspects of acupuncture would be culturally appropriate for Māori. This thesis has argued for example that the thorough intake process and time taken to holistically understand patients are integral to acupuncture practice and its therapeutic success. Māori also emphasise the importance of health practitioners' ability to listen to their stories, and the establishment of trusting therapeutic relationships (Anonymous, 2008). In an increasingly pluralistic healthcare environment, and one where traditional Māori healers may not always be accessible, the potential for other modalities (or the lessons learnt from them) to meet Māori needs warrants some consideration.

5.7 Chapter summary

Chapter five has discussed the research findings in light of contemporary literature. It has demonstrated that patients' reasons for using acupuncture are sometimes complex and cannot be reduced to a simple push-pull binary. Broadly consistent with international research, this study suggests that acupuncture is most often sought for treatment in the areas of musculoskeletal, gynaecological, pain-related and mental health issues, many of which are difficult to treat with biomedical approaches.

Whereas initial access is often motivated by lack of satisfaction with biomedicine, with increased exposure to acupuncture other factors become more significant.

The discussion has also outlined the impact of funding source, and the referral and communication behaviours of other health practitioners.

The understandings generated from data analysis and from considering other qualitative studies illustrate that there are many aspects of the therapeutic encounter integral to acupuncture treatment. Many of these components of therapy influence treatment outcomes, which are perceived to be wide ranging and include the relief of symptoms, increased well-being, changes to understanding and health behaviours. They have demonstrated that health beliefs, particularly an affinity with holistic and vitalistic ideologies lends to some patients' scepticism of certain biomedical approaches and creates a preference for therapeutically conservative and holistic approaches to healthcare, and correspondingly engenders an attraction towards acupuncture. Finally, it has briefly discussed how the philosophical basis and practice model of acupuncture—and CAM more generally—might have some congruence with Māori perspectives by drawing parallels between hauora and holism.

6 STRENGTHS AND LIMITATIONS OF THE STUDY

6.1 Strengths of the study

The current study provides a comprehensive exploration of the experiences and perceptions of acupuncture users and is, as far as I am aware, the first attempt to provide such an account from a New Zealand perspective. Male and female participants were included and all provided responses that were both thoughtful and thorough. Interviews were conducted in such a way as to ensure that statements had been understood as much as possible, with clarification sought whenever necessary. Each interview was transcribed allowing a methodical and thorough analysis.

Some phenomenological authors have proposed that data collection should continue until no new themes emerge (Morse & Field, 1996), while others have argued that theoretical saturation is incongruent with the aims of interpretive phenomenology, which seeks only to interpret what can be said for the people involved. While aspiring to the former goal, I must concede that some variation was still apparent at the end of data collection, but felt that in essence participants' stories had become sufficiently repetitious to indicate saturation.

Established research procedures and an approach congruent with the aims of the project have been used and the findings should convey some measure of credibility.

6.2 Limitations of the study

Since this research was completed within the context of a master's thesis—with the attendant time and resource constraints—its magnitude and depth were necessarily restricted, and like any study there are a number of limitations that

relate to the sampling and data collection processes.

Firstly, the recruitment methods inherently predispose the study to volunteer bias where the self-selected participants may be somehow different to the general population. Rosnow and Rosenthal (1975) established that people who actively offer to participate in research tend to be 'more educated, come from a higher social class, are more intelligent, are more approval-motivated... unconventional, nonauthoritarian, and nonconforming' (Boughner, 2010). It is especially hard to know how influential such bias is in this study since many of the attributes described above tend also to characterise CAM users (Eisenberg et al., 1998; Fox, Coughlan, Butler, & Kelleher, 2010; Gross, Liu, & Bauer-Wu, 2007; Wyatt, Sikorskii, Wills, & Su, 2010). Having made no direct attempts to address this challenge within the study design, it is acknowledged as a limitation nonetheless. Other conceivable sources of volunteer bias include that those whom had benefited from acupuncture were more likely to participate or that some participated out of a sense of obligation to their providers (Holloway & Wheeler, 1995). The measures taken to address this issue are described in chapter 3.2.

There are undoubtedly variations in how traditional acupuncture is practiced (Five Element versus TCM style, for example), and since participants' views were based on their exposure to a small range of practitioners, it could be argued that their experiences are not necessarily typical or representative. Additionally, the application of purposive sampling and a relatively small number of interviewees mean that findings from this research cannot be widely generalised (nor does the research approach lend itself to such an end). Nevertheless, the concordance demonstrated with other similar studies seems to

confer a degree of fittingness and transferability to the findings.

In communicating with respondents, I introduced myself in my primary role in relation to the research, i.e. as a post-graduate health science student. During the interview process or in preceding conversations, a number of participants learnt that I was also a practicing acupuncturist. While every attempt was made to conduct interviews in such a manner as to facilitate open and candid expression, it is important to consider how my background as a practitioner may have shaped the direction of interviews or participants' responses. Interviews also implicitly carry a power differential and the possible influence in this regard cannot be ignored. I hope however, that by explicating and acknowledging these potential sources of bias, a degree of transparency at least is availed to the reader.

7. CONCLUSIONS AND IMPLICATIONS

7.1 Conclusions

In its literature review this thesis synthesised previous studies of patients' experiences and highlighted the need to better understand the role that personal health beliefs play in treatment choices. It is the first study to have specifically investigated the health beliefs of acupuncture patients' and has shown that initial usage is often pragmatic, and related to the failures of other interventions, but that personal health beliefs—particularly subscription to holistic and vitalistic ideologies—often inspire more extensive and ongoing use. It has shown that while dissatisfaction with biomedicine often relates to lack of effectiveness for particular conditions, it sometimes also stems from patients' scepticism towards reductionist ontologies of health and approaches to healthcare.

As the first of its nature to be conducted in New Zealand, this study has uncovered some issues that are unique to a local context. In particular, it has shown how the various players, and structural components in the New Zealand health system impact on patients' experiences and use of acupuncture. Lack of information; inexpedient referral and access to funding may hinder utilisation, while poor interdisciplinary communication undermines patient safety and satisfaction.

Additionally a Māori perspective has been briefly explored and has hinted at the resonance that may exist between Māori, Chinese medicine and other CAM ontologies.

The findings from this research generate a number of implications for practice, scenarios of IM, and future research—the most germane of which find some discussion below.

7.2 Implications for practice and IM

Since the explosion of research interest in the 1970s, acupuncture has been increasingly been accepted/co-opted within conventional healthcare. Concerted efforts have been made to explain acupuncture scientifically and biomedical practitioners who have appropriated the technique have done so by distancing themselves from traditional theoretical models (Cheng, 2011; Vickers & Zollman, 1999). The question has been asked however, whether acupuncture or other similar CAMs will achieve the same successes when extricated from the paradigms under which they have been traditionally practiced. This thesis has argued that the attraction of acupuncture for patients and many of its perceived benefits lie in therapeutic components that are ultimately embedded in traditional Chinese medicine (holistic) theories of health. Like other forms of CAM, 'it may be that these approaches are effective because they are incorporated in a broad-based "wellness" paradigm' (Coulter, 2004, p. 115).

For practitioners this study should reinforce the significance of contextual factors in the therapeutic encounter. The retention of a holistic model of care, close patient-practitioner relationships, and thorough consultation processes are essential if patients are to continue reaping the full value of therapy. The impact that poor communication on patient safety is also underscored; patients may not report adverse events if practitioners are uncommunicative in their practice.

The study also has some implications for biomedical practitioners. It has reinforced the need for the patient to be understood as a whole person; that experiences of "illness" are often not synonymous with "disease"; and that "treatment" may not always meet the patient's needs. The stress—which affects

both doctors and patients—associated with treating medically unexplainable or untreatable conditions in primary care is well documented (Butler & Evans, 1999; Ring, Dowrick, Humphries, & Salmon, 2004; Salmon, Peters, & Stanley, 1999; Zantinge, Verhaak, Kerssens, & Bensing, 2005), and greater appreciation of when medical treatment may not be appropriate could expedite onward referral, forgo the frustration of repeatedly applying ineffective (and potentially harmful) interventions, free up doctors' time to help patients with whom they are better equipped to help, and reduce the likelihood of patients' becoming disenchanted with biomedicine.

CAM's 'penetrative stability within daily society' (Montgomery, 1993, p. 69) makes it imperative for policy makers to acknowledge its presence within a broader scheme of healthcare. Many New Zealanders are already extensively engaged in CAM use and a reversal of this trend seems highly unlikely in the foreseeable future. This study has underlined that most patients are left to mediate the dual use of biomedical and CAM therapies themselves; to interpret this scenario as a form of "integration" is semantically ambiguous, if not disingenuous.

Concerns about safety have been expressed widely with respect to dual CAM and biomedical modality use (for example in relation to possible herbal/pharmaceutical medicine interactions) (Izzo & Ernst, 2001). Addressing the issue of dual biomedical/CAM use and its potential problems (and benefits) has primarily focussed on patient's disclosure of CAM use with their doctors, which they often fail to do (Eisenberg et al., 2001). Patient-driven information exchange relies on sufficiently open patient-practitioner relationships (which in turn relies on practitioners who are willing to discuss other modalities openly

and objectively, and the time to engage in such discussion), and patients' ability to understand and articulate the various interventions that they have used (which may be multifarious and complex). An additional problem in relying on this type of information sharing is that it is essentially unidirectional. While it is clearly important for a doctor to know what herbs a patient might be taking, for example, it is equally important that an acupuncturist have reliable information about the drugs and other biomedical therapies their patients may be using, lest they expose patients to unnecessary risk.

The current dearth of interdisciplinary communication does nothing to allay concerns about patient safety and the appropriateness of some therapeutic decisions. People are increasingly seeking biomedical professionals who are prepared to work cooperatively with their CAM practitioners and the communication barriers that have been identified in this study (particularly, negative or adversarial inter-professional attitudes) can make healthcare encounters inefficient and tedious for patients, or worse lead to forgoing the most appropriate form of care. It thus behoves doctors to remain cognizant of how their attitudes and behaviours are perceived by their patients and to consider how more cooperative and constructive relationships might be fostered with the CAM practitioners involved in their patients' care.

Within conventional healthcare EHRs have facilitated better information exchange and promise to improve patient outcomes. At the time of writing this thesis, the Canterbury District Health Board (CDHB) in New Zealand is beginning to implement the Shared Care View EHR system. In this system, patients' GP records will be made visible to other clinical staff involved in their care, such as hospital clinicians or pharmacists (CDHB, 2013) with the intention of delivering

faster and safer care. Laudable though this initiative might be, the opportunity for facilitating information exchange more broadly—between the CAM and biomedical workforce—has so far been ignored. It may be up to both practitioners and patients themselves to advocate for access to EHRs as one strategy for moving forward with IM. Whilst acupuncturists remain professionally divided and unregulated in New Zealand, it seems unlikely that appeals for inclusion in such initiatives would be taken seriously however. Therefore the primary imperative for practitioners may be to work collaboratively towards statutory regulation in order to advance the agenda of IM.

7.3 Implications for research

Practitioners and publically accountable agencies such as ACC who fund treatment are increasingly expected to justify expenditure on interventions by providing sound evidence. The generation of evidence however requires significant financial resources and while spending on CAM research has increased over recent decades, it still only comprises a tiny fraction of overall expenditure (Khorsan, Coulter, Lewith, Kirk, & Mittman, 2014). If the agenda for IM is to be pursued, the greater provision of evidence will be imperative, which will be contingent on a significant increase in funding for CAM research.

This study has underscored the need to acknowledge traditional acupuncture as a complex ‘practitioner-oriented’ practice that often entails multiple and simultaneous therapeutic elements including health promotion practices. It has demonstrated that many of the treatment effects regarded as most significant by patients tend not to relate to changes in disease

(pathological) states, but to those contingent on personal and necessarily subjective, conceptions of health. Furthermore it has argued that traditional clinical trial models have limited utility in measuring such effects, reinforcing the need to consider patient-centred perspectives in outcome measures.

There are research challenges specific to acupuncture/CAM that require innovative methodologies if appropriate model-fit validity is to be achieved. Guidelines that have informed the evaluation of individualised, complex interventions exist and have already been applied in conventional healthcare settings (Craig et al., 2008). These offer a foundation upon which appropriate CAM research methods may be based. Several methodologies including Comparative Effectiveness Trials (CER) or Pragmatic Trials, mixed methods studies and observational studies offer promise in developing a better understanding of CAM in order to promote evidence-based practice.

Though relatively few pragmatic trials of acupuncture have been undertaken (Sherman, Linde, & White, 2007), this methodology is considered appropriate for several reasons. Firstly it affords the opportunity to conduct rigorous research within the context of “normal” individualised care, accommodates the divergent theoretical basis of Chinese medicine, and bypasses many of the troublesome methodological issues (for example achieving satisfactory placebo controls) that have plagued RCT design. CER can be applied to heterogeneous populations, such as those with complex comorbidities, which might normally be excluded from trials. Additionally and perhaps most importantly from a funding perspective, CER can compare different therapies and provide information about the cost-effectiveness of interventions in their natural practice setting. CER is not without its drawbacks however, and while it

is possible to determine the effect an intervention has, insight into its specific mechanisms may not be inferred.

Observational and mixed methods studies may be helpful to augment CER by providing greater insight into the health encounter and generate a more nuanced understanding of the various components of therapy and their specific effects and magnitude.

While some of these methodologies offer the possibility for rigorously assessing CAM without having to bend practice to conform to more traditional research methodologies, they do not address a greater challenge. As long as the current evidence hierarchy (with RCTs and meta-analyses at its apex) is accepted as singularly valid, it is unlikely that the types of research described above will carry sufficient weight to influence policy or funding. The challenge then is to critically analyse whether this hierarchy serves healthcare provision and decision-making as well as it once did. Perhaps the time has come to embrace a more pluralistic, indeed holistic, schema for assessing evidence to advance IM and better meet patients' needs.

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Appendix A – Medical Subject Heading (MeSH) scope notes

CINAHL

Firstly search terms were defined using the CINAHL HEADINGS tool.

The following search terms were selected:

- ‘Acupuncture’ is used based on the Scope Note which uses the definition, “The piercing of specific peripheral nerves along specific pathways or meridians with needles for therapeutic purposes. Specifics available.”
- ‘Health Beliefs’ is defined in Scope Notes as ‘Personal beliefs that influence health behavior.’
- ‘Alternative therapies’ is used in CINAHL to cover complementary medicine, CAM and related terms. There is no ‘Scope’ note for Alternative Therapies, however the Scope Note for Alternative Medicine suggests ‘...For alternative or complementary medicine use ALTERNATIVE THERAPIES.’
- ‘Allopathic medicine’ is used in reference to biomedicine (in contrast to Alternative therapies, Traditional Chinese Medicine etc.) Scope Note: “System of disease treatment based on the use of drugs, surgery, and radiation. Considered to be the most common medical system used in developed or western countries.”
- ‘Patients’ is used for individuals seeking health care. Scope Note: “General only; prefer specifics. Do not use /classification or /education; prefer precoordinated headings PATIENT CLASSIFICATION or PATIENT EDUCATION. Consider also INPATIENTS or OUTPATIENTS.”

ISI

No Thesaurus/Headings tool available

MEDLINE

Search Terms defined using

- ‘Acupuncture’ is used and defined by the Scope Note as, “The occupational discipline of the traditional Chinese methods of ACUPUNCTURE THERAPY for treating disease by inserting needles along specific pathways or meridians.’ This was chosen for the purpose of the search instead of ‘ACUPUNCTURE THERAPY’ which is defined as “Treatment of disease by inserting needles along specific pathways or meridians. The placement varies with the disease being treated. It is sometimes used in conjunction with heat, moxibustion, acupressure, or electric stimulation.’ Since this term does not relate specifically to ‘traditional’ acupuncture.
- ‘Complementary Therapies’ is used in MEDLINE to cover complementary medicine, CAM and related terms. The MeSH definition is “Therapeutic practices which are not currently considered an integral part of conventional allopathic medical practice. They may lack biomedical explanations but as they become better researched some (PHYSICAL THERAPY MODALITIES; DIET; ACUPUNCTURE) become widely accepted whereas others (humors, radium therapy) quietly fade away, yet are important historical footnotes. Therapies are termed as Complementary when used in addition to conventional treatments and as Alternative when used instead of conventional treatment.”

- 'Attitude to Health' is used instead of 'Health Beliefs'. MeSH term is "Public attitudes toward health, disease, and the medical care system. Note: includes attitude to disease"

PsychINFO

Uses the same terms/headings as CINAHL except:

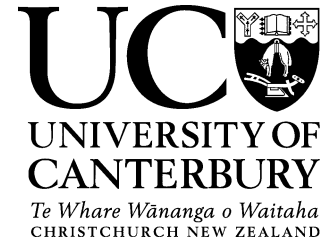
- 'Alternative Medicine' Treatments, health care practices, or culturally based healing traditions which are not generally used in conventional medical practice

PubMed

Firstly search terms were defined using the CINAHL HEADINGS tool.

The following search terms were selected:

- Acupuncture in MeSH terms is defined as 'The occupational discipline of the traditional Chinese methods of ACUPUNCTURE THERAPY for treating disease by inserting needles along specific pathways or meridians.' Year introduced: 2002
- Attitude to Health "Public attitudes toward health, disease, and the medical care system.
- Patients "Individuals participating in the health care system for the purpose of receiving therapeutic, diagnostic, or preventive procedures. Year introduced: /education was used for indexing 1966-1979
- Complementary Therapies "Therapeutic practices which are not currently considered an integral part of conventional allopathic medical practice. They may lack biomedical explanations but as they become better researched some (PHYSICAL THERAPY MODALITIES; DIET; ACUPUNCTURE) become widely accepted whereas others (humors, radium therapy) quietly fade away, yet are important historical footnotes. Therapies are termed as Complementary when used in addition to conventional treatments and as Alternative when used instead of conventional treatment.



HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2013/47

29 May 2013

Dan Jakes
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Dan

The Human Ethics Committee advises that your research proposal “Patients' experiences of acupuncture in Christchurch - a hermeneutic phenomenological study” has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 25 May 2013.

Best wishes for your project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'L. MacDonald'.

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee



HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2013/47

10 June 2013

Dan Jakes
School of Health Sciences
UNIVERSITY OF CANTERBURY

Dear Dan

Thank you for your request for an amendment to your research proposal "Patients' experiences of acupuncture in Christchurch - a hermeneutic phenomenological study" as outlined in your email dated 6 June 2013.

I am pleased to advise that this request has been considered and approved by the Human Ethics Committee.

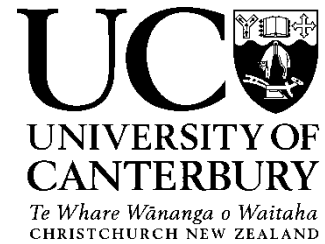
Yours sincerely

A handwritten signature in black ink, appearing to read 'L. MacDonald'.

Lindsey MacDonald
Chair, Human Ethics Committee

Appendix D - Letter to practitioners

College of Education
School of Health Sciences
Mob: 021 408 036
Hm: 366 5058
Email: dan@sanctuaryhealth.co.nz



Dear NZRA member

I am conducting a study, "Patients' Experiences of Acupuncture in Christchurch - A Hermeneutic Phenomenological Study" as a part of a Masters of Health Sciences thesis research project.

As part of this study, I will talk to consumers of acupuncture to ask questions about their health beliefs, and experiences of receiving acupuncture. The research will be written up in a thesis and may be published in an academic journal to guide future research in this area.

To recruit participants, I would like to display posters advertising the study in the clinics of NZRA practitioners. If you would be prepared to display a poster advertisement in your clinic to advertise the research, please contact me by email or phone.

Yours Sincerely,

A handwritten signature in blue ink, appearing to read 'Dan Jakes'. The signature is stylized with a large, sweeping 'D' and 'J'.

Dan Jakes
MNZRA

Are you receiving acupuncture?



I am a Masters student at the University of Canterbury School of Health Sciences undertaking research into the use of acupuncture.

In this research I am interviewing people to learn about their experiences of acupuncture.

Your input would be greatly appreciated.

Interviews will take around 30-60 minutes to complete and are completely confidential.

If you would like to participate, please contact Dan Jakes by email: dan@sanctuaryhealth.co.nz or phone: 021-408-036 or 03-366-5058

Acupuncture research
dan@sanctuaryhealth.co.nz
021 408 036 or 366 5058

Acupuncture research
dan@sanctuaryhealth.co.nz
021 408 036 or 366 5058

Acupuncture research
dan@sanctuaryhealth.co.nz
021 408 036 or 366 5058

Acupuncture research
dan@sanctuaryhealth.co.nz
021 408 036 or 366 5058

Acupuncture research
dan@sanctuaryhealth.co.nz
021 408 036 or 366 5058

Acupuncture research
dan@sanctuaryhealth.co.nz
021 408 036 or 366 5058

Information Sheet



**Patient Experiences of Acupuncture in Christchurch
Information Sheet**

University of Canterbury
School of Health Sciences
College of Education
University of Canterbury
Private Bag 4800
Christchurch 8140

21 March 2013

Researcher: Mr Dan Jakes (Contact details: Telephone: +64 3 366 5058
Email: dan@sanctuaryhealth.co.nz)
Research supervisors: Assoc Professor Ray Kirk (Contact details:
ray.kirk@canterbury.ac.nz)
Dr Lauretta Muir (Contact details: lauretta.muir@canterbury.ac.nz
)

I am a Masters student at the School of Health Sciences at the University of Canterbury. I am undertaking research into the use of acupuncture in Christchurch and would like to invite you to participate in this evaluation.

The research

The aim of the research is to identify why people use acupuncture and how they see its role in improving health.

Your role in the research

If you agree to take part you will be asked to do the following:

I will contact you to make a time to interview in a place that is convenient to you. The interview will take approximately 30 minutes, will be recorded on a digital recorder and transcribed into a written transcript. You will have the opportunity to review the transcript if you wish.

You do not have to answer any of the questions asked if you feel they are inappropriate or make you feel uncomfortable and can stop the interview at any stage. You can withdraw from the study at any stage with no penalty.

The benefits of the research

The purpose of the research is to understand the type(s) of conditions you have had treated with acupuncture, how effective have you found acupuncture to be and your reasons for choosing to use acupuncture.

Confidentiality

Your identity and the information you provide will be treated in a confidential manner. Your name will not be used any reports or publications about the research. Information that may identify you will not be used or given to anyone else. Only the research team will have access to the list of people who were involved in this research.

You can withdraw any information relating to you until December 2013.

All the information collected will be stored for a period of five years in a locked cabinet at the University of Canterbury. All researchers on the project will sign confidentiality agreements.

The results of the research will be used in a thesis and may be published in an academic journal at a later date. Upon completion, you are welcome to receive a copy of my research.

You may contact my supervisors, Dr. Lauretta Muir on 366 7001 ext 6146, Assoc Prof. Ray Kirk on 364 3108 or myself if you have any questions about the study at any stage.

This project has received ethical approval from the University of Canterbury Human Ethics Committee, and participants should address any complaints to The Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you have any questions about the study, please contact me on Telephone: +64 3 366 5058 Email: dan@sanctuaryhealth.co.nz. If you have a complaint about the study, you may contact either Assoc Professor Ray Kirk, Dr Lauretta Muir or the Chair, Educational Research Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

If you agree to participate in this study, please complete the attached consent form and contact me by [Day/Month]. You can either return the consent form by email, post it to the above address or give it to me at the time of the interview.

Does your study require HDEC review?

This flowchart summarises the definition of the scope of HDEC review in section 3 of the *Standard Operating Procedures for Health and Disability Ethics Committees*.

1. Main criteria

Will your research use or create a human gamete, a human embryo or a hybrid embryo?

no

para 20

Does your study involve **human participants** recruited in their capacity as:

- consumers of health and disability support services, or
- relatives/caregivers of such consumers, or
- volunteers in clinical trials?

no

para 27.1

Does your study involve the use, collection or storage of **human tissue** (as defined by the Human Tissue Act 2008)?

no

para 27.2

Does one or both of the exceptions at paras 27.2.1 and 27.2.2 of the SOPs apply to this use, collection or storage?

no

yes

Does your study involve the use or disclosure of health information (as defined by the Health Information Privacy Code 1994)?

no

para 27.3

Does one or both of the exceptions at paras 27.3.1 and 27.3.2 of the SOPs apply to this use or disclosure?

no

yes

Your study must be approved by the Ethics Committee on Assisted Reproductive Technology (www.ecart.health.govt.nz).

2. Exemptions

Does your study involve a medical device that is (or would be) classified as a low risk (class I) medical devices by Australia's Therapeutic Goods Administration?

no

para 28

Is your study a minimal risk observational study?

no

paras 29, 30

Is your study an audit or related activity?

no

para 31

Does your audit or related study involve the use, collection or storage of human tissue without consent?

no

Does a statutory exception to the need to gain informed consent apply to this use, collection or storage?

yes

no

Is your study an observational study that is to be conducted for the purposes of an educational qualification at Masters level or below?

no

para 32

yes

YES.
HDEC review is required for your study.

NO.
HDEC review is NOT required for your study.

3. Inclusions

Does your study involve the use of Guthrie cards?

yes

no

para 33.1

Is your study:
• funded by the Health Research Council, and
• not able to be reviewed by an HRCEC-approved university ethics committee?

no

para 33.2

Does your application involve the establishment or maintenance of a tissue bank?

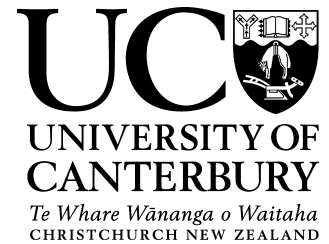
yes

no

para 33.3

College of Education

School of Health Sciences
Tel: +64 021408036
Email: dan@sanctuaryhealth.co.nz



Research project title: “Patients’ Experiences of Acupuncture in Christchurch - A Hermeneutic Phenomenological Study”

Principal Investigator: Dan Jakes

Supervisors: Assoc Prof. Ray Kirk and Dr. Lauretta Muir

CONSENT FORM

I understand that:

- My participation in this project is voluntary. I understand that I will not be paid for my participation.
- I have the right to withdraw from the project at any time without penalty. If I choose to withdraw, any of the information relating to the project will be removed from any final publication, provided that this remains practically achievable.
- I will be interviewed about my use of acupuncture.
- The interview will be audio recorded and transcribed by the researcher.
- I will be given the opportunity to view the transcribed interview.
- All information collected will be confidential and will not be released by the researcher to a third party unless required to do so by law.
- The information I provide in the interview will be used in a thesis and may be published in an academic journal, but that all personally identifiable information will be removed.
- If I am uncomfortable answering any of the questions asked, I do not need to answer them.
- All interview recordings will be kept in a locked and secured facility and password protected in electronic form.
- All data (interview recording and transcripts) will be securely stored for five years, and then destroyed.
- The project has been reviewed **and approved** by the University of Canterbury Human Ethics Committee and any complaints can be directed to the Chair, University of Canterbury Human Ethics Committee.
- I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

Name (please print):

Title:

Email:

Signature:

Date:

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"Patients' Experiences of Acupuncture in Christchurch

- A Hermeneutic Phenomenological Study"

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Date 13/2/13

Appendix K - Interview questions prompt sheet

If you don't understand what I'm asking please ask me to clarify the question.
Feel free to elaborate on anything that you think is interesting.

- What symptoms/conditions did you get acupuncture for?
- How did you come about to have acupuncture treatment?
- What are your experiences of treatment?
- How effective have you found acupuncture for these conditions?
- Why did you choose acupuncture over other therapies?
- How was your treatment funded?
- How did you choose an acupuncturist, were you referred by someone?
- Do you expect to continue using acupuncture in the future, why and what for?
- Where do you think acupuncture fits in the health system as it is (i.e. do you see it as conventional, alternative, complementary medicine), why?
- Where do you feel acupuncture should fit within the health system (i.e. remain as it is, move to greater incorporation etc)?
- Is your relationship with your acupuncturist different to other health providers?
- What is it about acupuncture that is different?
- Did your practitioner explain diagnosis, how did she explain it and what does it mean to you?
- What is your understanding of TCM theories of health?
- How do you reconcile differences between TCM and biomedicine?

Appendix L - Scenarios of Possible Integration
(Note. adapted from MACCAH, 2004)

Example 1: Integration through consumer choice

Over the past year or so, Renee has been getting migraines. She has gone to her general practitioner who has recommended that she take tablets when she feels the start of a migraine. This has usually been effective in stopping the more severe effects of the migraine but a friend has suggested that Renee see her acupuncturist who has recommended acupuncture treatment, along with changes to her diet.

Example 2: Integration through practitioner training in both biomedicine and CAM

Jenny spent the weekend digging up a section of the lawn for a new flowerbed. She felt a bit tired on Sunday night but on Monday morning, found she could barely walk. Something had happened to her back. She phoned her work and her manager suggested a doctor who 'specialised in backs'. Jenny decided to follow up the recommendation. She found the doctor also specialised in Chinese medicine and prescribed her a course of Chinese herbs to help her recover from the injury along with some prescription medicine for pain relief.

Example 3: Integration through practitioner referral

Robyn is the owner/manager of a small health practice in a semi-rural location. She is a physiotherapist. Other members of the practice include a general practitioner, a chiropractor, a naturopath, a massage practitioner/aromatherapist, a podiatrist and a counsellor. An older woman, Mary, visits Robyn who treats her for arthritis in her knee. Mary mentions digestive problems she has been experiencing and Robyn suggests that she take advantage of the 'Two for the price of one' appointments that are currently being offered by the doctor and the naturopath. Visiting the doctor will mean that Mary can get access to subsidised diagnostic tests which will establish if there is a serious underlying condition responsible for her condition. The naturopath will conduct his own diagnoses and with Mary's permission the two practitioners will discuss her case and develop some suggestions before her next appointment.

Example 4: Integration of practitioners in secondary care

Unit 'Ex' is a specialist unit for those that experience severe or chronic pain. Practitioners working in 'Ex' include biomedical specialists with training in various fields of medicine, nursing and psychology. They have found that for many patients effective pain management and relief involves a multi-disciplinary approach. Some staff members have also broadened their skills through undertaking training in therapeutic massage, acupuncture, and art therapy, and they bring in CAM expertise from practitioners on an asneeded basis. To find out who might be appropriately skilled in the area they contact the professional organisations who are generally able to provide names of local practitioners with appropriate training.

Example 5: Integration – a policy and funding issue

For some time, the 'Wai' District Health Board has been aware that in one of the district's hospitals, patients have requested visits from CAM practitioners. This has generally been tolerated on the understanding that in-patients pay for these visits themselves and have received any treatments during visiting hours to avoid interfering with hospital routines. Some patients have requested visits from practitioners outside visiting hours. At another location, both staff and patients have requested the use of aromatherapy atomiser and have forwarded a pile of articles on the benefits of aromatherapy in secondary health care settings. 'Wai' has checked with the Ministry of Health but there are no guidelines in this area.